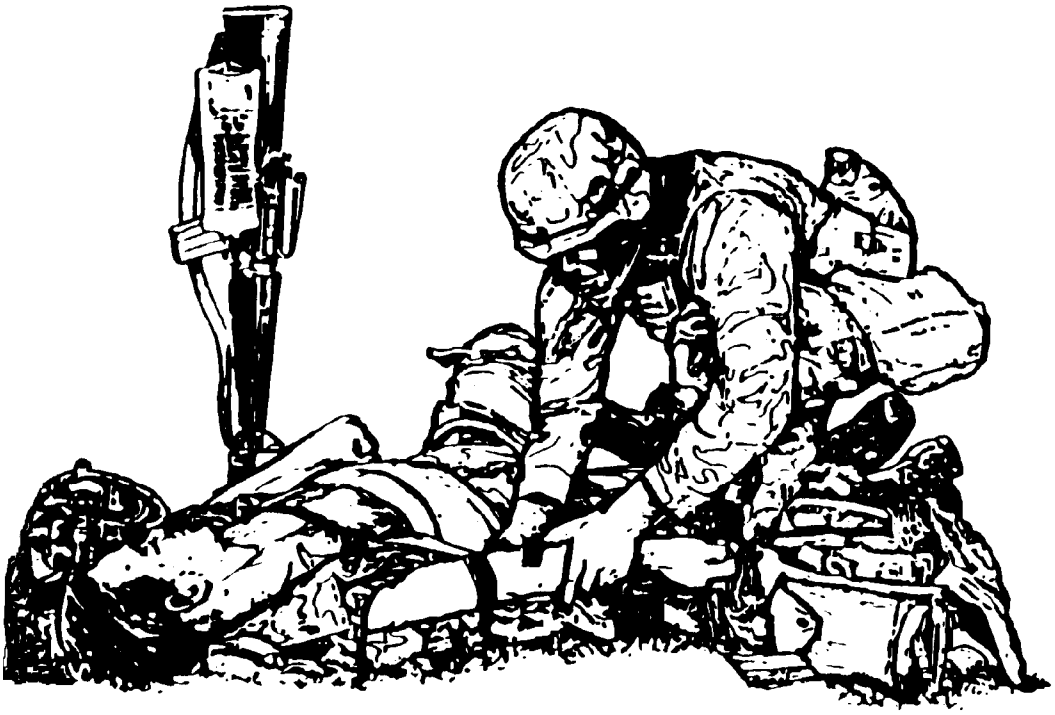
U. S. Army Medical Department Center and School

Doctrinal Review Team



Handbook For Leaders

December 1996

Fort Sam Houston, Texas 78234-6175

United States Army Medical Department Center and School

Doctrinal Review Team

COMBAT HEALTH SUPPORT TRAINING AT THE COMBAT TRAINING CENTERS

The United States (US) Army Medical Department Center and School (AMEDDC&S) Doctrinal Review Team (DRT) initiated several trips to the combat training centers (CTC) to examine the application of doctrine in simulations and field exercises. The CTCs visited included: the National Training Center (NTC) at Fort Irwin, California; the Joint Readiness Training Center (JRTC) at Fort Polk, Louisiana (and formerly Fort Chaffee, Arkansas); the Combat Maneuver Training Center (CMTC) at Hohenfels, Germany; and the Battle Command Training Program (BCTP) at Fort Leavenworth, Kansas. The desired outcome was to create a direct link between the CTCs, the training units, and the AMEDDC&S on doctrinal issues using the Doctrine, Training, Leadership, Organization, Material, and Soldier (DTLOMS) matrix.

The CTC experience provides medical units an opportunity to practice and test their skills in a realistic battlefield setting. It also allows the units to incorporate new training methods and ideas into their home station unit training plans that will strengthen unit readiness and improve unit tactical standing operating procedures (TSOPs). During the CTC visits, the DRT collects observations of the training activities conducted by the participating units. These observations are then categorized using the DTLOMS matrix. The observations are further analyzed; recommendations are made to resolve the issues identified; corrective actions are tracked; trends are determined; and the resulting *lessons learned* are validated and disseminated for use by the Army Medical Department (AMEDD) community.

This handbook is the product of these DRT visits. It is intended to be used as a reference for units participating in CTC rotations and as an aid in unit training. This handbook is not authoritative. If a conflict exists between it and approved Army doctrine, the approved doctrine prevails. It will be updated on a periodic basis.

Units can also obtain other medical lessons learned information on the world wide web at http://www.acs.amedd.army.mil. Questions or assistance required with AMEDD lessons learned can be obtained by writing the **U.S. Army Medical Department Center and School, ATTN: MCCS-F, 2250 Stanley Road, Fort Sam Houston, Texas 78234-6120** or telephonically at DSN 471-8171 or commercial (210) 221-8171.

THE ARMY MEDICAL DEPARTMENT FUNCTIONAL AREAS

The AMEDD functional areas include: command, control, communications, computers, and intelligence (C^4I); patient evacuation and medical regulating; hospitalization; dental services; preventive medicine (PVNTMED); combat stress control (CSC); veterinary services; medical laboratory support; combat health logistics; and area medical support.

When developing the combat health support (CHS) plan, all functional areas should be considered even if not all functional areas are organic to the echelon of support. For example, hospitalization resources first appear on the battlefield at Echelon III. The forward support medical company (FSMC) (Echelon II) must still incorporate hospitalization information into its CHS plan (such as which hospitals are supporting the FSMC).

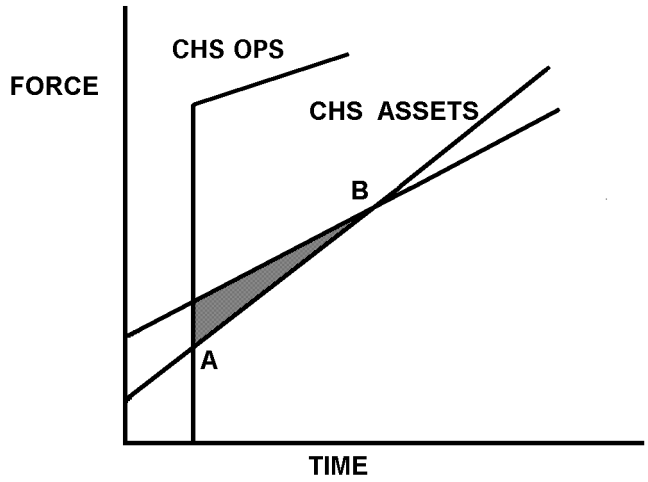
THE FORWARD SUPPORT MEDICAL COMPANY

During the initial stages of an operation, a gap may exist between the anticipated number of patients and the FSMC's ability to care for these patients. Combat health support planners must ensure that sufficient CHS resources are included in the initial stages of the plan. Further, the CHS commander must ensure that medical equipment, medical equipment sets, and medical supplies are current, on hand, and operational to ensure that the maximum number of patients can be cared for during the initial phases of an operation.

It is important for leaders and planners to know the commander's intent and understand the operational tempo of the mission and the projected number of patients. This has been the "fog of planning" when trying to identify and align resources with mission requirements.

Observation: ***Combat health support planners have difficulty visualizing an effective combat health support (CHS) plan.***

The following chart is a CTC initiative developed to help planners visualize and better understand how to support forces arriving into a theater of operations (TO) over time. This chart compares when combat operations start (line A) and CHS assets (line B) with projected patient estimates over time.



(NOTE: These estimates do not consider conventional or nuclear, biological, or chemical mass casualty situations.) The point B intersection shows the CHS assets aligned with the patient estimate whereas the point A intersection shows that CHS assets fall considerably short of supporting the patient estimate during the initial stages of a conflict. The shaded area represents the **potential risk** that a brigade commander can face during combat operations.

The following major medical observations and trends highlighted in this publication are—CHS planning, medical equipment, patient evacuation, and Class VIII (medical) resupply. They are followed by several checklists located in the annexes.

COMBAT HEALTH SUPPORT PLANNING

CHS planning needs the leader's attention. The forward support battalions (FSB) coming to the CTCs do not accomplish effective CHS planning prior to arrival. They do not conduct mission analysis and

develop courses of action (COAs) based on the tactical plan. They often have very little intelligence, and are unawares of the medical threat in theater. Some soldiers often rely on the notion that "whatever happens initially will have to wait till we get there," forcing the unit to develop a wait-and-see attitude.

The scenarios normally start with deployment of a brigade task force (TF) into the maneuver box, followed by the brigade supporting assets. Depending on the scenario, a corps hospital, forward surgical team (FST), mobile aeromedical staging facility (MASF), aeromedical evacuation control center (AECC), aeromedical evacuation control team (AELT), or medical assets of a Naval ship/fleet may also be capable to provide support the brigade task force. Each of these elements has actually played at the CTCs with the exception of the Navy hospital ship which has been included notionally.

Considering availability, the brigade staff plans and schedules the order of who arrives into the maneuver area via convoys and aircraft. Where the brigade and battalions position their organic CHS assets into the flow will have a dramatic impact on their ability to provide quality CHS if they immediately receive enemy contact and start sustaining casualties. When this occurs, the battalion aid stations (BASs) are often overwhelmed trying to clear the battlefield and coordinate the evacuation of these patients to the FSMC which is normally not yet on the ground (as identified in the A and B line intersect points).

Observation: ***When the FSMC arrives and is on the ground, it takes on average between 24 to 36 hours before an effective CHS system is established.***

Observation: ***There was virtually no CHS input into the brigade operation plan (OPLAN) and there was a lack of rehearsals. This resulted in delays caused by confusion at the soldier level and throughout the chain of patient evacuation.***

There is a high correlation between the number of patients that died from their wounds and having a weak CHS plan. A key consideration to successful CHS planning includes the use of standard and nonstandard evacuation platforms.

Observation: ***During a combat service support (CSS) rehearsal, the FSB support operations officer coordinated to have the FSMC commander, the BAS platoon leaders, and attached medical elements (such as the corps medical evacuation assets and combat stress control (CSC) teams) present to rehearse their supporting roles during each phase of the mission. Further, each of the battalions first sergeants were present during rehearsals. As a result, the brigade task force (TF) effectively executed the CHS plan.***

The development of the CHS plan should follow the guidance provided in CHS doctrine. However, commanders and staff officers should realize that they may be required to adopt tactics, techniques, and procedures to execute this doctrine which are not specifically addressed in doctrinal publications. An understanding of CHS doctrine, especially the CHS principles (conformity, continuity, control, proximity, flexibility, and mobility) assists the CHS planner to better formulate the OPLAN. Considerations in the CHS plan include, but are not limited to—

Treatment. Know where the medical treatment elements are located on the battlefield. It has been observed during numerous rotations that CHS elements deployed forward can be combat multipliers when effectively controlled. Further, a strong combat lifesaver program can enhance the ability of the combat medic to provide far forward treatment. The attachment of corps assets, such as FSTs, can also provide additional capability during the initial stages of an operation when effective and timely medical evacuation may be restricted.

Patient Collecting Points and Battalion Aid Station (Minus). Patient collecting points provide an area where patients awaiting evacuation to a medical treatment facility (MTF) can be gathered. This facilitates the medical evacuation assets ability to acquire patients in a timely manner. These patient

collecting points are designated on the medical evacuation overlays. These points do not require staffing. Should the CHS planner and/or commander determine that forward treatment is required at these points, a treatment element can be deployed forward to establish a battalion aid station (BAS) (minus). Once this occurs the point is designated as an MTF location and is no longer considered a patient collecting point. Unit First Sergeants need to know where the unit patient collecting points are located so they can disseminate this information to platoon and squad leaders.

Health Maintenance. Maintaining the overall health of the command is a combat multiplier. Several medical units actually conducted Preparation for Overseas Movement (POM) prior to their CTC deployment. Some units have had personnel deploy to the CTCs medically unfit to perform their duties, which created leadership challenges and mission time delays within the maneuver area.

Patient Holding. The FSMC can hold 20 (light divisions) to 40 (heavy divisions) patients for up to 72 hours. During the initial phases of an operation, medical evacuation may limited due to the lack of medical evacuation resources for evacuation out of the area of operations (AO). The brigade needs to consider that once patient treatment begins, it must continue whether the patient is in an MTF or in the evacuation system. Combat training center medical units have suffered very high died of wounds (DOW) rates when patients were evacuated to the FSMC for stabilization and further evacuation out of the AO. A comprehensive and coordinated medical evacuation plan is required to ensure that patients do not remain in the FSMC beyond the established time requirements.

Medical Evacuation. Units have an evacuation capability, but it is often not identified in any plan. The observed results often lead to an accumulation of casualties requiring further evacuation, but no concept of how to accomplish it. Rehearsals and the availability of litter bearers and evacuation platforms (ground, air, and nonstandard) are key components to any medical evacuation plan. Additional considerations include—

- Medial threat.
- Patient estimates.
- Areas of patient density.
- Lines of patient drift.
- Size of the force to be supported.
- Availability of additional support (US Air Force, US Navy, allies, coalition partners, or host nation).
- Availability of medical personnel to provide en route medical care on nonstandard evacuation platforms.

Planning Coordination. Another CHS planning consideration is the lack of coordination among the brigade S-1, surgeon, FSB support operations officer (Health Services Support Officer [HSSO]), FSMC commander, battalion S-1, and battalion medical platoon leaders. The confusion multiplies when the corps hospital, division medical operations center (DMOC), forward support MEDEVAC team (FSMT), and other CHS detachments are available, yet are not integrated into the planning process.

Several times, the CHS plan was written by the brigade S-1 (not coordinated with the S-4) who normally had a limited medical background and received virtually no input from any of the key medical personnel. This "vacuum planning" within the brigade often produces an inadequate CHS plan. The integration of brigade CHS assets into the tactical plan for evacuation of casualties is critical. The CHS plan must be developed by those who are doctrinally mandated, in concert with the brigade tactical planners, to ensure synchronization, integration, and coordination of all participants.

In an immature theater, the correct mix of medical elements/specialties is imperative to the brigade commander starting on day-one (D-day). In many cases, the elements of the corps support slice and the DMOC are not included in the planning process.

Observation: ***More brigades are bringing personnel from their DMOC to assist the brigade in medical evacuation, Class VIII and blood management, any other aspects of CHS management. Good DMOCs are invaluable for facilitating the medical evacuation process.***

An effective CHS plan is critical to the success of any potential military operation. Staff involvement is imperative because, as a rule, "when the fighting does start, 90% of what needs to be done needs to be thought out ahead of time. The remaining 10% will undoubtedly consume almost 100% of a soldier's time and energies."

Observation: ***A brigade Executive Officer (XO) was told to "take the initiative" by the brigade commander on D+3 of the battle to fix the medical evacuation system because "it was broken." Rehearsals had not been conducted, so the problem (high DOW rates and no CHS plan) was not identified and addressed by the brigade commander until D+3.***

Planning should not start when the units hit the ground, or on D+3, but start from home station.

MEDICAL EQUIPMENT

In the majority of rotations, medical equipment has not been maintained in a high state of readiness. Most FSMCs cannot provide x-ray services in the field. Either their x-ray machines are malfunctioning prior to arriving, they have not been calibrated, or personnel are not properly trained to operate the equipment. Therefore, many RTD patients are evacuated to a higher echelon of care because the FSMC cannot perform all of its authorized functions. This has been a systemic problem with the majority of FSMCs observed.

Other pieces of the medical equipment overlooked for preventive maintenance checks and services (PMCS) are oxygen tanks (and the procedures for how to have them refiled) and laboratory equipment. Medical equipment sets are often not stocked accordingly. It is often observed that medical personnel in the treatment tent cannot find the items they need on an immediate basis. This is due to a lack of SOPs and familiarization with MESs. This disorganization and lack of familiarization with field medical equipment and MES often results in major delays in the delivery of health care.

Medical maintenance personnel often deploy to the CTCs without their assigned equipment because "there was no room for it," or they were told to just "leave it behind." Therefore, medical equipment needing repair in the field stays "broken" until the unit redeploys back to home station.

EQUIPMENT	SERVICE STATUS
X-ray	• Not calibrated correctly. • Missing components. • Missing required supplies (film and/or chemicals). • Lacking safety equipment. • Turned in at home station for repair and not available for training.
Laboratory	• Missing pieces of equipment. • Reagents out dated. • Missing storage capability for blood products.
Dental	• Generally good. • Missing some components for the hand-held x-ray.
Class VIII	• Packing lists for MES missing or incomplete. • Medical equipment set not functionally packed and packing list is not readily available. • Medications outdated. • Drawers in MES are not labeled. • No procedures established for ordering resupplies. • Contents of MES changed from authorized items.
Medical Maintenance	• Not aware of MEDSTEP program. • No procedures established to evacuate equipment which cannot be repaired at this echelon.

CLASS VIII (MEDICAL) RESUPPLY

Class VIII consumption at the CTCs is demonstrated by placing the required medical supplies with each patient based on the patient's medical condition (MILES casualty cards are used). All wounds are dressed and fractures are splinted. Overall, the FSMCs have demonstrated a need to improve medical supply inventory procedures. All too often, FSMCs deploy to the CTCs without an inventory of what Class VIII supplies are on hand, are on requisition, or are required.

Often, on or about the fifth day of battle, the medical supply section of the FSMC runs out of medical supplies and which results in the FSMC's inability to continue to treat treat patients. This issue also affects the BAS as they are resupplied by the FSMC and, therefore, they normally run out of medical supplies as well. In the majority of cases, the FSMC commander is not apprised of the situation until it is too late to take effective corrective actions. In planning for the deployment to the CTC, Class VIII and blood management issues are often not considered and sustainment/resupply are not planned for. Without a Class VIII resupply plan, the treatment and evacuation system falters. The unit is responsible for developing their Class VIII resupply plan in conjunction with either their DMOC or a forward distribution team. The combat health logistics (CHL) plan can also include requests for blood (simulated) and litters from the CTCs which are available to the medical units if properly requisitioned.

Observation: ***Forward support medical companies do not have blood management SOPs nor are they familiar with the procedures necessary to prepare and administer blood to their patients.***

MEDICAL EVACUATION

Within the FSMC, one of the most critical functions performed is the evacuation of patients from Echelon I to the Echelon II clearing station and preparing those patients unable to RTD at Echelon II for further evacuation to the rear. The provision of en route medical care is the distinguishing factor between casualty transport and medical evacuation.

The capacities of medical evacuation platforms for the US Armed Forces is provided in the Annexes.

In medical evacuation operations at the CTCs, a major area of concern is the lack of coordination that occurs between the FSMC and BAS. Because of the potentially long lines of communication (LOCs), it becomes imperative that medical units know the location of supported units, radio frequencies used for requesting evacuation, and where casualties will be located on the battlefield (lines of patient drift and patient collecting points) during each phase of an operation. Planning should include the use of nonstandard evacuation assets for the less seriously injured in mass casualty situations.

Aeromedical Evacuation. Another CTC observation concerns Army aeromedical evacuation units. Again, units do not conduct sufficient home station training subsequent to deployment to the CTCs. Aeromedical evacuation units designated to provide direct support to participating FSMCs are not included in the planning and preparation phases of the medical evacuation portion of the CHS plan prior to deployment. They also do not receive adequate orientation and integration into the FSMCs operations and are expected to accomplish their mission without sufficient coordination/training. Some of these areas include—

- Procedures for requesting medical evacuation support.
- Dedicated frequency for medical evacuation.
- Location of the forward support MEDEVAC team (FSMT).
- Release authority (control).
- Army Airspace Command and Control considerations and requirements.
- Logistical support requirements (fuel and maintenance).
- Crew rest/flying hours/night vision goggles requirements.
- Flight surgeon requirements.

During two separate CTC rotations, it was observed that the evacuation liaison team (ELT) was introduced to control corps air and ground medical evacuation assets. One of the key factors for the ELT was location. During one rotation, a ELT liaison officer (LNO) (67J) collocated forward with the FSMC that resulted in better use, control, and security coordination. Army air was directly tied into the FSMC's command post (CP) and maximized. The FSMC commander was comfortable with this situation of executing his release authority.

During the other rotation, the ELT remained in the rear and was facilitate and expedite the aeromedical evacuation process. Questions/situations posed by the FSMC commander such as, "Where is MEDEVAC and are they available now? Why can't I get them? and I need them now!" went unanswered. The principles of control and proximity are key considerations to the CHS plan.

Ground Evacuation.

Observation: ***During convoy movements, ground ambulances were not ready to receive patients due to an overload of TOE equipment loaded in the rear of the ambulances.***

Ground evacuation and ambulance load plans vary from unit to unit. Good ambulance load plans will assist the ambulance teams with evacuation of patients, expected or unexpectedly. Poor ambulance load plans create not only major delays in the evacuation process, but real-world concerns of what to do with the TO&E equipment that is loaded in the back of ambulances and needs to be immediately unloaded to make room for the patient(s). Supervisors need to ensure that vehicle load plans are followed and teams are given good convoy briefings as to what the mission is (never assume), an intelligence update, and the patient evacuation plan.

Due to the varying depths and rear security problems, security escorts often complemented survivability. During one FSMC After Action Review (AAR), an NCO (Vietnam veteran) commented that they "neglected to get an intelligence update from their S-2 prior to launching our ground ambulances" on D+5 and were "sending our ambulances forward without any security considerations." The ambulances were ambushed on the night of D+5. The NCO commented, "In Vietnam, we never sent our ambulances out unless they had an armed escort. We must not forget the lessons learned from Vietnam. . . . The need for current intelligence is crucial to the success for any operation. . . . It will never happen again in my platoon. . . . . a valuable lesson learned."

Briefing unit personnel is a key factor that happens infrequently (OPORDs, FRAGOS). During one rotation, an ambulance platoon leader used a "5-point contingency plan" for each evacuation mission along with daily intelligence updates. Before each ambulance went out on a mission, they had to receive the following information—

- Where is the team was going? Grid coordinates, strip maps, and route reconnaissance.
- Who is in charge? Second in charge?
- Time. How long will the mission take?
- What actions will take place if a team does not return?
- Actions. What does the team do if engaged by the enemy while en route or at their destination? Frequencies checked? Security escorts?

Evacuation by US Air Force Assets. Requesting USAF assets for patient backhaul is often the platform of choice for evacuation during the initial stages of an operations. US Army medical personnel often lack the experience and knowledge in loading and unloading patients onto C-130s and preparing the proper documentation the USAF requires (DD 601s and 602s). Units that have had the opportunity to conduct rehearsals minimize the amount of "blade time" wasted on the flight landing strip.

Observation: ***The evacuation system often becomes hindered and time consumed due to the fact that the Air Force does not maintain a supply of litters on-hand to exchange with the Army when a litter patient is transferred to them. The Army's system conducts a one-for-one exchange at each level of patient transfer. So when Army medical personnel load patients onto a C-130, the litters, straps, and blankets go with them.***

Movement of Patients to the MASF. The DMOC was unaware of patients being moved from the FSMC to the MASF via the ELT. This created confusion and emotional discussion on the flight landing strip. Due to poor coordination on the movement of patients, the MASF was not prepared to receive them--they were all returned to the FSMC. Three hours later, the patients were back and accepted by the MASF for evacuation (C-130 in bound). Comment: The movement of patients must be closely controlled. A MASF can accommodate only limited numbers of patients over time. Patients cannot be evacuated to the MASF earlier than 3 hours prior to arrival of the aircraft and no later than 1 hour prior to arrival. Coordination is key. (Refer to FM 8-10-6 for additional information.

Patient Care. The FSMC evacuated several patients to the MASF, some in semi-stable condition and/or in conditions that had deteriorated en route. The MASF was "not prepared for these type of patients." Comment: The MASF is a temporary holding facility. It is equipped and staffed to receive

patients, sustain life, and administratively process them. It is not a MTF or depository for patients. There are no physicians assigned and patients must be in stable condition prior to being evacuated to a MASF.

Litter Exchange. This was a problem for the FSMC. The FSMC was expecting a one-for-one exchange of litters due to the limited number of litters available. With no litter resupply plan, the system came to a halt. Comment: The equipment available at a MASF is limited and there is no exchange of equipment with the user.

AELT Coordination. The FSMC welcomed the AELT, but was caught off-guard with their logistical requests. Comment: The AELT depends directly upon the user service for the logistical support. It was planned that the Army was responsible to provide quarters, food, and other logistical support as required. The FSMC commander was not prepared for this, but quickly overcame the situation.

Evacuation—US Navy Considerations

On several rotations, a Naval TF notionally supported the brigade, but planning for the use of the amphibious TF was not accomplished. This is due to in part to our lack of any habitual training relationship in the joint service arena. When the amphibious TF medical support was considered (through coaching, teaching, and mentoring), it was often maximized for the seriously injured patients.

Observation: ***Personnel are unfamiliar with the amphibious task force medical support capabilities; therefore, they often do not consider, ask for, or recognize it.***

Observation: ***Army pilots who are not deck-qualified have problems gaining immediate access to Naval ships.***

The Navy has a tremendous capability of not only providing a projection of force via sea lanes, but also of providing immediate medical support to the forces.

OTHER AREAS OF CONCERN

Other major problem areas for leaders and staff include—

Patient Holding. There is a lack of experienced personnel in providing patient-holding services (up to 72 hours, if required). Deficiencies have been noted in the maintaining of accurate patient accountability logs; development, use, and availability of standing operating procedures (SOPs); properly annotating the DD Form 1380, US Field Medical Card with treatment provided; familiarity with field medical equipment; and the maintenance of MES.

Preventive Medicine Support. The preventive medicine (PVNTMED) personnel attached to the FSMC for CTC rotations are normally junior enlisted personnel. These soldiers are a valuable assets for the deployed unit, but must be fully integrated into the unit of attachment and provided leadership, guidance, and support. All too often, units deploy without all authorized PVNTMED equipment and supplies.

Combat Stress Control. Probably one of the most important CHS assets that goes untapped.

Observation: ***During one rotation, a CSC team was collocated at the FSMC and proved to be valuable asset for the brigade commander once the actual battle began on D-day.***

Unit Layout. Unit layout is dependent upon a number of factors, such as--the terrain features in allotted real estate; the anticipated duration of occupation; defensive considerations; and the available cover. To enhance the delivery of health care, the layout of the unit area should maximize:

Patient Flow. Patient-flow considerations within the established facility dictate the placement of the triage area, treatment tents, x-ray and laboratory areas, FST (if attached), and patient holding areas. Patients should be able to flow through the treatment chain without experiencing areas where bottlenecks are created by cross traffic or having to back-track over already covered ground. The more smoothly the patients flow through the MTF, the more efficiently and effectively CHS will be provided.

Ambulance Turn Around Points. The treatment platoon leader and the ambulance platoon leader normally will work out a plan of how the traffic will flow through the FSMC. Where the plan commonly falls apart is that not everyone in the FSMC and FSB are aware of it. Thorough coordination, comprehensive planning, and clearly visible signs will alleviate traffic jams by maintaining one-way traffic through the unit area. The plan for traffic flow through the unit area should be widely disseminated and rehearsed.

Triage. The triage area should be established and clearly marked. In many cases, the dental officer serving in his alternate wartime role is the designated triage officer. Regardless of who the triage officer is, his guidance and determinations should be followed. All too often, other personnel try to second guess and/or change designations made by the triage officer. This causes confusion and delays the prompt treatment of the most seriously wounded.

Professional Officer Filler System (PROFIS) Personnel and Other Attached Personnel. During most CTC rotations, personnel not normally assigned to the unit are attached for the purpose of participating in the CTC training. These personnel include PROFIS, corps support personnel, and replacement personnel for unit members who are nondeployable. If these personnel are not oriented to the new unit, provided predeployment training, and integrated into its operation, the training they receive is not maximized but, more importantly, the unfamiliarity with their duties can adversely impact on the delivery of health care provided by the unit. This is a leadership issue which must be immediately addressed and corrective action taken.

Geneva Conventions Considerations. Combat health support leaders must educate nonmedical leaders on the provisions of the Geneva Conventions that affect CHS operations. They must also educate them on the consequences to both medical personnel and their patients if these provisions are not upheld. As the United States is a signatory to these Conventions, CHS operations must be conducted in accordance with their provisions. Often times, nonmedical leaders will propose actions which are in contravention of these provisions (such as placing nonmedical personnel [mechanics] or weapons not authorized for use by medical personnel on ambulances).

CLOSING STATEMENT

This guide is a start in sharing and improving medical readiness. Though programmed to complement the AMEDD Officer Basic Course Platoon Leaders Exercise at Fort Sam Houston, Texas, it can also be utilized to assist in unit readiness from a CTC level. This guide will assist the soldier in visualizing and developing a CHS plan. It also provides the soldier with knowledge of lessons learned. Our goal: To conserve the fighting strength and win.

Charlie Mike, Sir!

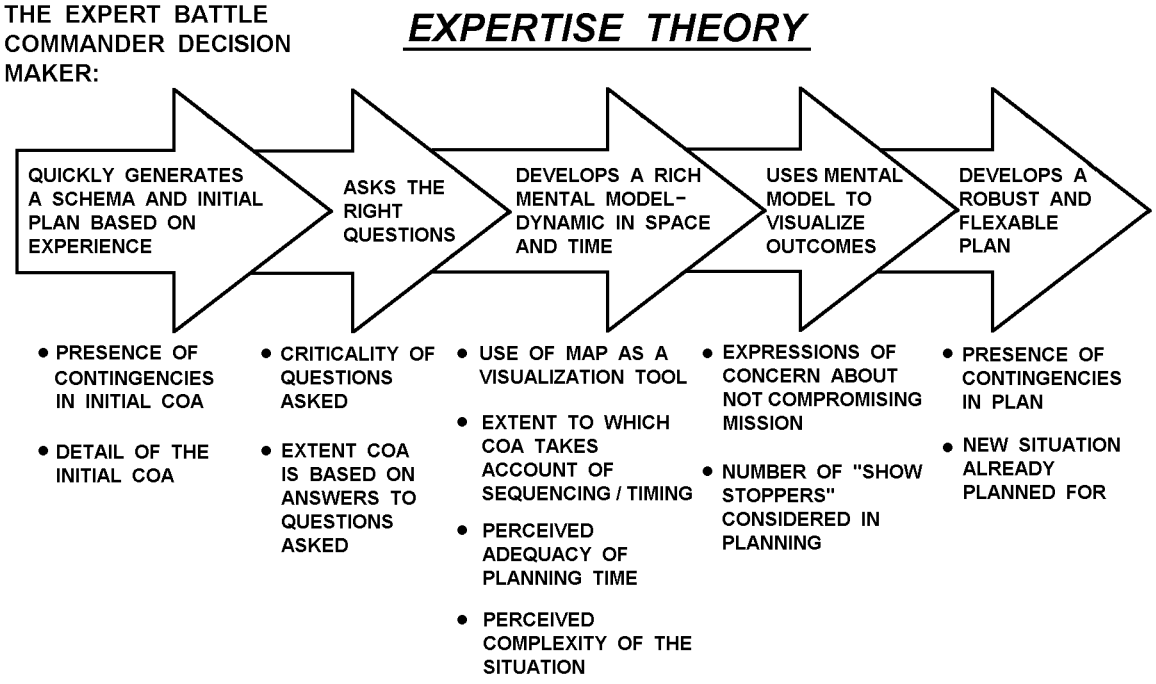
LISTING OF ANNEXES

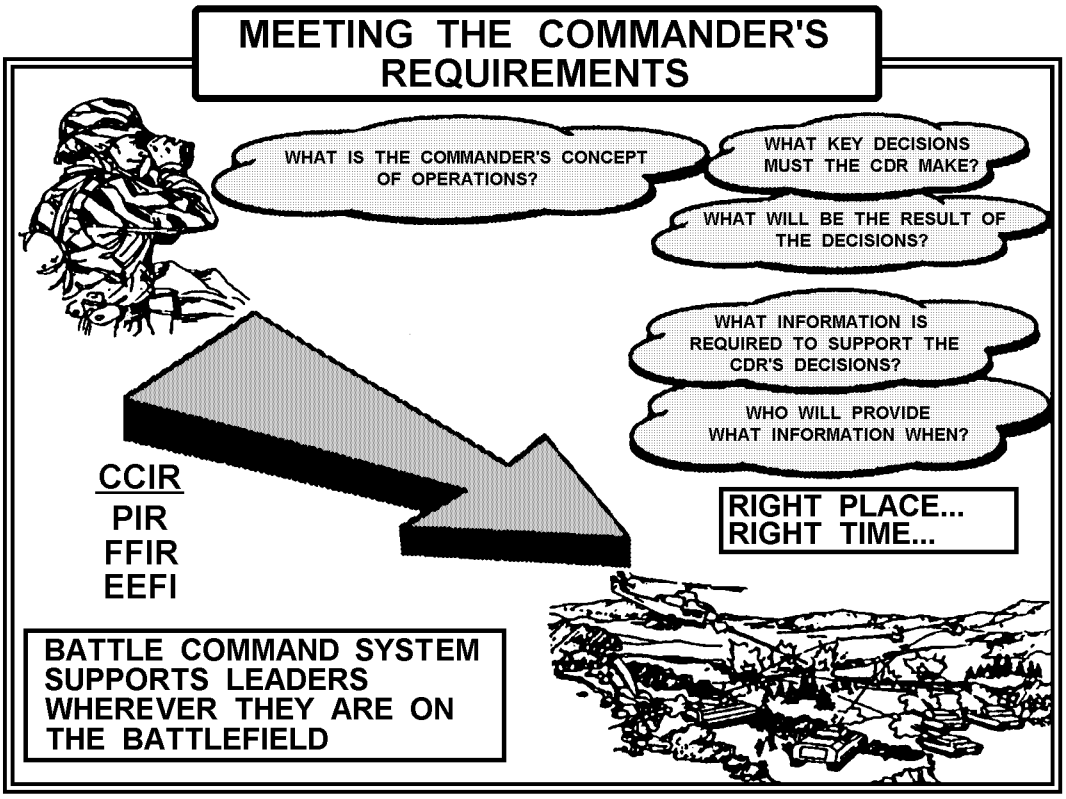
ANNEX A

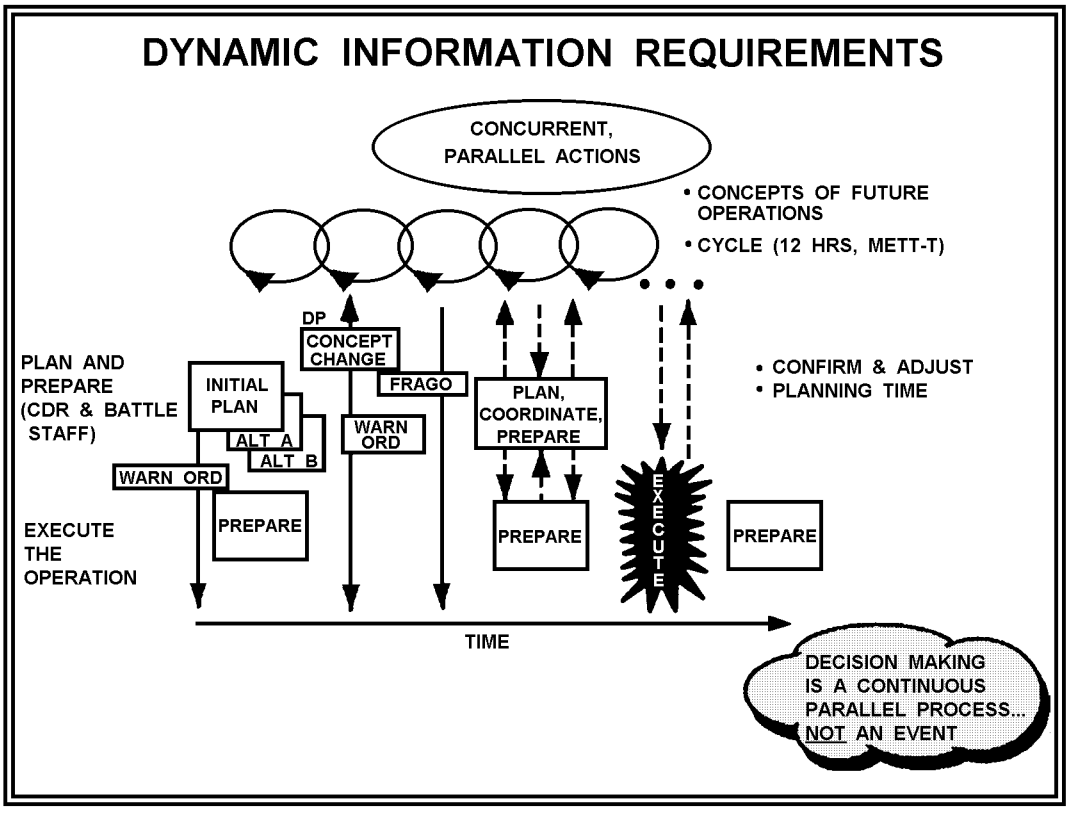
COMMAND (TACTICAL) DECISION MAKING

Included in Annex A are:

- Chart: Expertise Theory.
- Graphic: Meeting the Commander's Requirements.
- Chart: Dynamic Information Requirements.
- Graphic: Current and Future Operations Considerations.
- Graphic: Planning and Preparation.
- Chart: Summary of Decision Making.
- Information: Visualizing Current and Future States and Formulating Concepts of Operations.
- Graphic: Visualization: Key to Success.

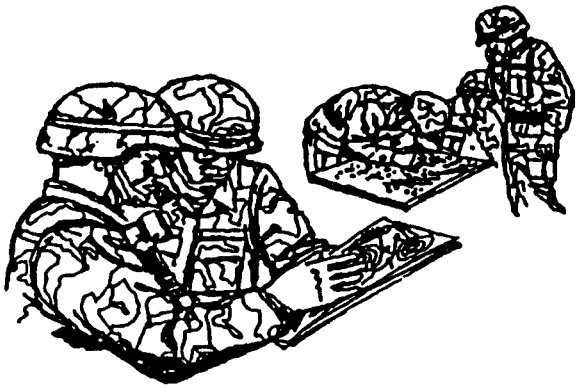



MEETING THE COMMANDER'S REQUIREMENTS
WHAT IS THE COMMANDER'S CONCEPT OF OPERATIONS?
WHAT KEY DECISIONS MUST THE CDR MAKE?
WHAT WILL BE THE RESULT OF THE DECISIONS?
WHAT INFORMATION IS REQUIRED TO SUPPORT THE CDR'S DECISIONS?
WHO WILL PROVIDE WHAT INFORMATION WHEN?
CCIR
PIR
FFIR
EEFI
RIGHT PLACE...
RIGHT TIME...
BATTLE COMMAND SYSTEM SUPPORTS LEADERS WHEREVER THEY ARE ON THE BATTLEFIELD


DYNAMIC INFORMATION REQUIREMENTS
CONCURRENT, PARALLEL ACTIONS
• CONCEPTS OF FUTURE OPERATIONS
• CYCLE (12 HRS, METT-T)
DP
CONCEPT CHANGE
FRAGO
PLAN AND PREPARE (CDR & BATTLE STAFF)
INITIAL PLAN
ALT A
ALT B
WARN ORD
WARN ORD
PREPARE
EXECUTE THE OPERATION
PLAN, COORDINATE, PREPARE
PREPARE
EXECUTE
PREPARE
• CONFIRM & ADJUST
• PLANNING TIME
TIME
DECISION MAKING IS A CONTINUOUS PARALLEL PROCESS... NOT AN EVENT

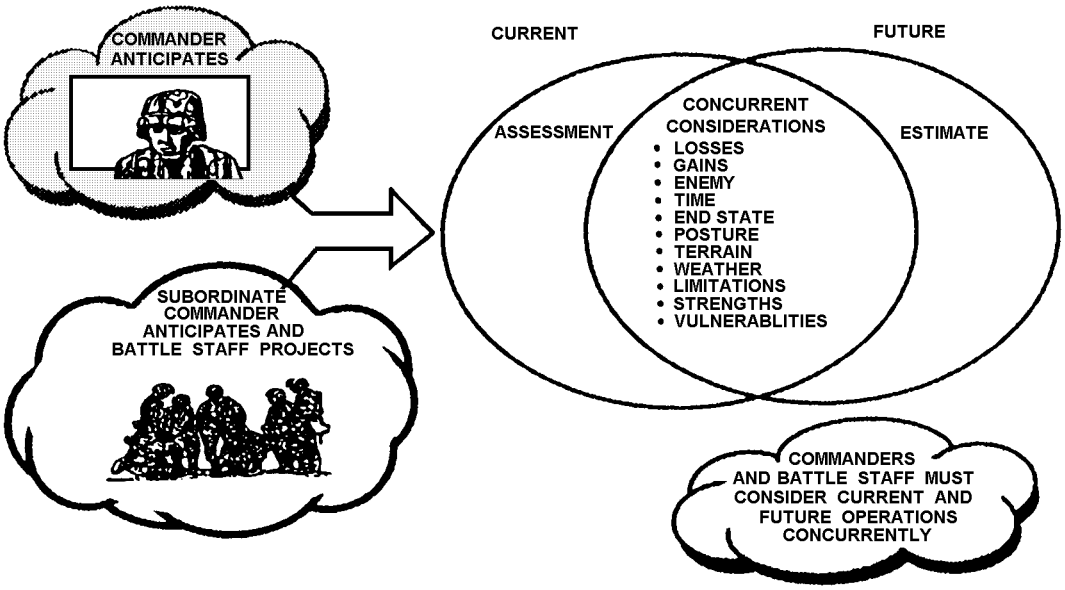
PLANNING AND PREPARATION

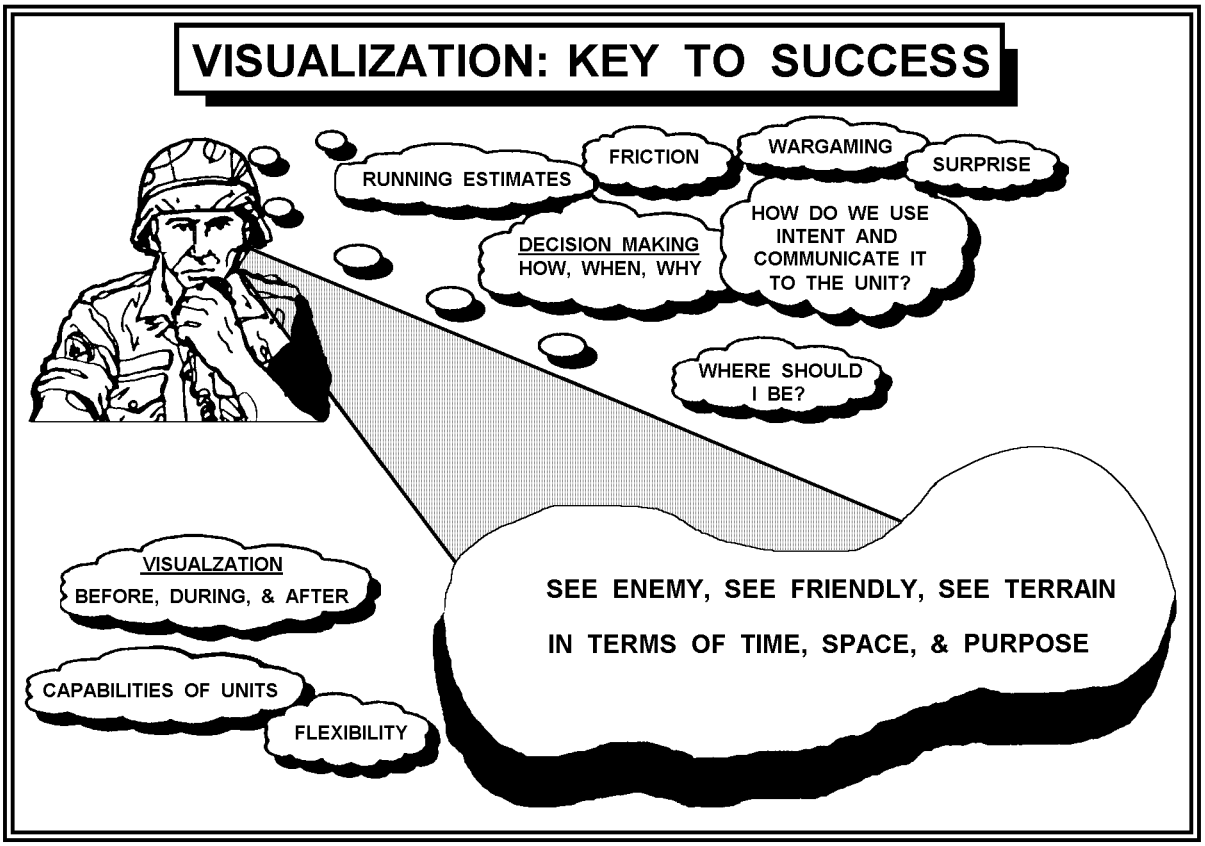
DYNAMIC PROCESS



THOROUGH PLANNING AND PREPARATION RESULTS IN INTEGRATED, COORDINATED, AND DECONFLICTED PLAN

CURRENT AND FUTURE OPERATIONS CONSIDERATIONS





VISUALIZING CURRENT AND FUTURE STATES AND FORMULATING CONCEPTS OF OPERATIONS

___ *Visualizing the battlefield* results from being able to see the enemy, the terrain, and yourself in terms of how these elements relate to each other in terms of time, space, and purpose.

___ *Seeing the terrain* is the result of:
- ___ Identifying decisive terrain.
- ___ Knowing the effects of terrain on enemy forces and your forces.
- ___ Understanding how weather and illumination impact on your forces.

___ *Seeing the enemy* is the result of:
- ___ Knowing their capabilities and limitations.
- ___ Identifying enemy strengths and weakness.
- ___ Attacking enemy weakness and avoiding enemy strengths.
- ___ Integrating the threat with terrain and your mission.

___ *Seeing yourself* in terms of time, space, and purpose is the result of:
- ___ Knowing strengths and weaknesses of your units and your subordinate commanders.
- ___ Knowing friendly capabilities and limitations.
- ___ Knowing how to integrate the battlefield functions with the dynamics of combat power.

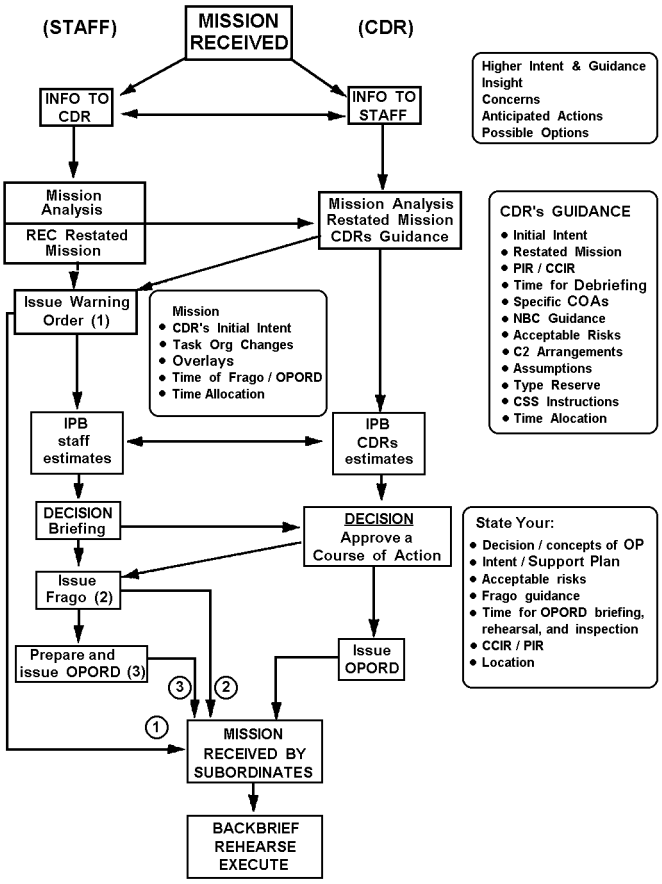
___ *Articulating your visualization.* The commander depicts his visualization of current and future states and his concept of operations so that they are understood by soldiers at least two echelons below.

SUMMARY OF TACTICAL DECISION MAKING		
ACTIVITIES	**RESULTS**	**WHEN PERFORMED**
PLANNING	Coordinated actions for execution.	Continuous. (Proactive not reactive.)
Situation Assessment	Visualization/understanding of the current situation. Forecasts of future situations and desired end state.	Continuous.
Mission Analysis	Understanding of the mission's goals, limitations, and opportunities (METT-T driven).	In anticipation of mission or upon receipt of warning orders or OPORDs.
Initial Commander's Guidance/Intent	Commander's guidance, goals, criteria for successful mission accomplishment, and vision of how situation will unfold. Determination of acceptable risks.	Early as possible after mission receipt or identification of opportunities.
Concept of the Operation	Scheme of maneuver, fires, reserves, combat multipliers—WHAT, WHEN, WHERE, HOW, and WHY.	Some elements are generated during mission analysis, continues to be refined through OPORD and monitoring.
Warning Order	Subordinates alerted to probable missions.	When general concepts of the operation are determined.
War gaming	Mission feasibility. CCIR. Refinements to operation. Identification of decision points, branches, and sequels.	Throughout to check the feasibility of concepts and to assess projected actions.
Synchronization	Arrangement and scheduling of battlefield activities. Plan for massing combat power in time and space.	Begin the concept of the operation and continues until battle activities are scheduled. Continuous.
Deception Planning	Concepts to mislead enemy; integrated into plans.	During concept development and refinement.
Contingency Planning	Identification and consideration of actions - reactions outside bounds of primary concept.	During and after concept development for branches and sequels which *(a)* identify likely enemy actions (situational), *(b)* are not covered in basic order, and *(c)* failure to prepare would lead to mission failure.

Operation Plan - Operation Order	Concept detailed and documented.	Begins when basic scheme of maneuver is determined. Completed so it can be distributed in time for won and subordinate's preparation within the higher command's schedule.
DIRECTING	Rehearsed operations. Guidance, orders, and plans.	Throughout, as needed.
MONITORING	Identification of deviations in actual performance from intent. Decisions to change on-going actions or establish new future actions. Supervision and spot-corrections.	Throughout, continuous.

ANNEX B

TACTICAL DECISION MATRIX



ANNEX C

SAMPLE EXECUTION MATRIX

Item	(a) WHEN	(b) WHO	(c) WHAT	(d) WHERE	(e) REMARKS
1	DTG	Ambulance Squad	2 ambulances establish AXP	VIC GRID	
2	DTG	Treatment Squad	Treatment team displaces forward	VIC GRID	Link up with 2Lt Jones

EXECUTION MATRIX

___ Item #. An item number given to identify the event.
___ When. Indicates as closely as possible the date time group (DTG) an event should take place.
___ Who. Indicates the personnel and equipment required to complete the task.
___ What. The event that must occur.
___ Where. Indicates location (vicinity [VIC] by grid).
___ Remarks. Additional information.

ANNEX D

PARALLEL PLANNING SCHEDULE

PARALLEL PLANNING SCHEDULE			
Action	**CO Time**	**Product to PLT**	**PLT Time**
Received mission/analysis			
Issue Warning Order		Mission (AO) time schedule	
Make tentative plan			
Initiate movement		Movement FRAGO	
Initial recon/instructions		Zone/sector named area of interest (NAI), target area of interest (TAI), C^2, and assets.	
Develop/update estimates			
Prepare OPORD			
Issue OPORD		Written OPORD with overlays and decision support template (DST)	
Immediate backbrief after OPORD		Backbrief format	
Prepare company execution matrix		Company execution matrix	
Formal backbriefs		Sand table sketch	
Communications check		Signal operating instructions extracts	
Rehearsals		Rehearsal area	
LD/SP/PZ time		Location and route	
Assembly time		Linkup plan	
Mission time		Redundant C^2 plan	

ANNEX E

PLANNING PARTICIPANTS AND THE ISSUE OF ORDERS

COMBAT HEALTH SUPPORT PLANNING PARTICIPANTS

The individuals involved in the planning and rehearsal process for CHS operations can include:

___ Brigade surgeon
___ Brigade dental officer
___ Battalion surgeons
___ Battalion HSSOs
___ Medical company commanders
___ Platoon leaders
___ Platoon sergeants
___ First sergeants

ORDERS ISSUE CHECKLIST

___ Agenda.
___ Task organization.
___ Intelligence overview.
    ___ Enemy situation.
    ___ Weather/light data.
    ___ Most probable COA.
    ___ Most dangerous COA.
___ Friendly situation.
    ___ Brigade mission.
    ___ Battalion mission.
___ Mission.
___ Execution.
    ___ Concept of the operation.
    ___ Scheme of maneuver.
___ Subunit tasks.
___ Coordinating instructions.
___ Service/support plan.
___ Command and signal.
___ Critical times.
___ Administrative notes.

ANNEX F

PRINCIPLES OF COMBAT HEALTH SUPPORT

Conformity

- Conformity with the tactical plan is the most fundamental element for effectively providing CHS.
- The CHS planner must participate in the development of the OPLAN to ensure adequate support at the right time and the right place.

Continuity

- CHS must be continuous; an interruption of treatment may cause an increase in morbidity and mortality.
- No patient is evacuated any farther to the rear than his physical condition or the military situation requires.

Control

- Technical control and supervision of CHS assets must remain with the appropriate force-level surgeon.
- CHS officers must be proactive. They must keep their commanders apprised of the impact of future operations on the availability of CHS resources.
- The CHS commander must be able to tailor CHS organizations, directing them to focal points of demand throughout his AO.
- Resources are limited; therefore, it is essential that control of resources be maintained at the highest CHS level consistent with the tactical situation.

Proximity

- Minimize medical evacuation time; allocate resources efficiently and locate MTFs judiciously.

Flexibility

- Distribute or relocate CHS resources to meet changing requirements.

Mobility

___ When totally committed to patient care, CHS units must have mobility comparable to the units they support.

___ A CHS unit can regain its mobility only by immediate patient evacuation.

ANNEX G

ARMY MEDICAL DEPARTMENT BATTLEFIELD RULES

AMEDD BATTLEFIELD RULES
(in order of importance)

- MAINTAIN MEDICAL PRESENCE WITH THE SOLDIER.
- MAINTAIN THE HEALTH OF THE COMMAND.
- SAVE LIVES.
- CLEAR THE BATTLEFIELD.
- PROVIDE STATE-OF-THE-ART CARE.
- RETURN SOLDIERS TO DUTY AS SOON AS POSSIBLE.

ANNEX H

TROOP LEADING PROCEDURES

TROOP LEADING PROCEDURES (TLP) CHECKLIST

___ Receive the mission.
___ Issue the warning order.
___ Make a tentative plan.
___ Initiate movement.
___ Reconnoiter.
___ Complete the plan.
___ Issue the order.
___ Rehearse the plan.
___ Supervise and refine the plan.

NOTE: TLP is a continuous process. The steps DO NOT occur in any specific order.

ACCELERATED PROCESS

In very time-sensitive situations, the commander must accelerate the planning process. When the process is conducted as parallel activities across echelons, time savings are possible. Issuing warning orders early aids parallel planning. A headquarters must tell subordinates as much as it knows as soon as possible. Other ways to accelerate the process include frequent updates, focusing on critical information, and remaining alert to what might happen.

DEVELOP ORDERS UNDER SEVERE TIME CONSTRAINTS

Even the most proactive organizations will have to develop orders under severe time constraints. High levels of expertise, intuition, and battlefield awareness are needed during these times. The commander and principal staff must quickly decide upon a feasible course of action, using existing information on METT-T. The emphasis is upon rapid selection of a COA that may not be optimal, but will meet the minimum mission requirements. The more time that is spent searching for the optimum COA, the less time there will be to do detailed planning, coordination, and rehearsal.

VERBAL EXECUTION ORDERS

Under extreme time constraints, the commander has to issue immediate verbal execution orders to subordinates. The staff must then continue to work out the details and coordinate with subordinate units as time permits. This type of situation is full of risk. The goal of good battle command is to avoid these situations, and correct any problems that may have caused them to occur.

EXAMPLE OF ACCELERATED TACTICAL PLANNING

TASK	TIME	PRODUCTS	WHO
Mission received	H-Hour	Situation template; warning order	Commander & S3
Mission analysis*	30 minutes	Situation update; restated mission	Executive officer and staff
Detailed guidance by BOS*	1 hour	Scheme of maneuver; scheme of fires; CSS (to include CHS)	Commander
Wargaming*	1 hour	Synchronization matrix; maneuver graphics; RSOI plan	Commander and staff
Issue oral OPORD	30 minutes		Commander
Complete plan	1 hour	Fire support plan	Executive officer and staff
Fragmentary order	15 minutes	Remaining products	Staff

*The CHS planner must be involved early in the planning process. Beginning with the mission analysis, the CHS staff officer/surgeon must be able to provide input into the development of the COAs to ensure that the impact of the medical threat is included in the analysis process. Further, the CHS planner must be intimately familiar with the development of the tactical plan to facilitate the CHS mission of clearing the battlefield and providing prompt, effective medical care.

ANNEX I

PRE-COMBAT CHECKLISTS

PRE-COMBAT CHECKLIST (GENERAL CONSIDERATIONS)

___ Unit leader receives the mission from next higher headquarters.
- ___ Clarifies any questions.
- ___ Coordinates with next higher headquarters as required.

___ Unit leader conducts mission analysis.

___ Unit leader produces the--
- ___ Restated mission statement.
- ___ Tentative time schedule.

___ Unit leader issues a warning order.

___ Unit members perform readiness, maintenance, and functional checks under supervision of leaders.
- ___ Medical equipment sets.
- ___ Vehicles.
- ___ Night vision devices.
- ___ Communications equipment.
- ___ Weapons and ammunition.
- ___ Field sanitation equipment and supplies.
- ___ Any special equipment (such as hoist and/or forest penetrator.)

___ Unit leader makes a tentative plan at a minimum.
- ___ Uses estimate of the situation to analyze METT-T information.
- ___ Develops COAs.
- ___ Wargames COAs.
- ___ Decides on COA to be used.

___ Unit leader completes his plan.

___ Unit leader issues his order.

___ Uses sand table and/or sketches to depict plan of support.

___ Unit leader or his designated representative conducts coordination for the mission.
- ___ Support requirements.
- ___ Current intelligence (to include medical threat) update.
- ___ Control measures.
- ___ Communications and signal.
- ___ Time schedule.

___ Unit leader receives attachments.
- ___ Attachments are briefed (such as forward surgical team or CSC elements).

___ Unit leader supervises CHS mission preparation.
- ___ Key leaders briefback the unit leader.
- ___ Key personnel rehearsals are conducted.
- ___ Leaders.
  - ___ Supervise.
  - ___ Inspect.
  - ___ Ensure adequate security.
  - ___ Conduct brief backs.
  - ___ Rehearse.
  - ___ Continue coordination.

___ Unit plans for the support of combat operations.
- ___ Analyze--
  - ___ Patient acquisition and medical evacuation requirements.
  - ___ Medical treatment (to include hospitalization) and area support requirements.
  - ___ Preventive medicine requirements
  - ___ Requirements for water, Class VIII, and other classes of supply.
  - ___ Requirements for NBC patient treatment and decontamination.
- ___ Determine transportation requirements.

___ Unit leader--
- ___ Executes a work/rest plan based on priorities of work.
- ___ Monitors current situation.
- ___ Issues appropriate FRAGOs based on intelligence or operational updates.
- ___ Reacts to messages or orders from higher headquarters.
- ___ Executes any actions or coordination resulting from change.

___ Unit headquarters remains current on positions and missions of higher headquarters and adjacent units.

PRE-COMBAT CHECKLIST FOR MEDICAL EQUIPMENT SETS

___ Medical equipment is properly calibrated and serviceable.

___ Medications, reagents, and other time-sensitive supplies are current.

___ All authorized MES are on hand and complete.

___ Each MES has packing list on hand.

PRE-COMBAT CHECKLIST FOR CLASS VIII

___ Authorized number of days of supply are on hand.

___ Medications, reagents, and other time-sensitive supplies are current.

___ Blood products, if authorized, are on hand.

___ Accountability of controlled substances is maintained.

___ Medical gases are on hand.

___ Medical equipment is on hand and calibrated, as required.

___ Optical fabrication materiel (to include protective mask inserts) is on hand, if appropriate.

___ Medical maintenance/repair support is coordinated.

PRE-COMBAT CHECKLIST FOR GROUND AMBULANCES

___ Authorized MES are on hand.

___ Medical equipment is complete and serviceable.

___ Authorized medical gases (oxygen) are on hand and serviceable.

___ Authorized medications are on hand and current.

___ Packing list is available.

___ Strip maps and/or road maps are available.

___ On vehicle equipment (OVM) is on hand.

___ Log book is present and current.

___ All drivers are licensed.

___ Situational awareness equipment (position locator) is on hand and serviceable.

___ Communications equipment is on hand, serviceable, and set to the correct frequency.

___ Medical unit identification markers (in accordance with the Geneva Conventions) are displayed. (Markers are red on a white background only; camouflaged or subdued markers are not authorized.)

PRE-COMBAT CHECKLIST FOR AIR AMBULANCES (MEDICAL ASPECTS ONLY)

___ Authorized MES is on hand.

___ Medical equipment is complete and serviceable.

___ Authorized medical gases (oxygen) are on hand and serviceable.

___ Rescue hoist/forest penetrator are installed, if required.

___ Authorized medications are on hand and current.

___ Medical unit identification markers (in accordance with the Geneva Conventions) are displayed. (Markers are red on a white background only; camouflaged or subdued markers are not authorized.)

PRE-COMBAT CHECKLIST FOR PREVENTIVE MEDICINE SUPPORT

___ All authorized equipment is on hand and serviceable.

___ Individual PVNTMED supplies (such as insect repellent) is issued to soldiers.

___ Individuals trained in the application of PVNTMED measures.

___ Unit field sanitation team trained.

___ Unit field sanitation team supplies are on hand.

___ Provisions for the use of chemical toilets have been coordinated, if appropriate.

___ Waste disposal procedures and facilities have been established.

PRE-COMBAT CHECKLIST FOR THE MEDICAL TREATMENT FACILITY

___ All authorized shelters are on hand and serviceable.

___ All authorized collective protective equipment is on hand and serviceable.

___ Procedures for management of medical waste are established.

___ Provisions for water supply are coordinated.

___ Patient protection measures are instituted (such as patient bunkers).

___ Ambulance turnaround is planned for and established.

___ Area for patient decontamination operations is planned for and established, when required.

___ Camouflage materiel is available if authorized for use.

___ Medical unit identification markers (in accordance with the Geneva Conventions) are on hand.

PRE-COMBAT CHECK ON NUCLEAR, BIOLOGICAL, AND CHEMICAL EQUIPMENT

___ Individual protective equipment (CPOG and MOPP) is on hand and serviceable. (One set is issued and the extra set remains in supply.)

___ Protective masks are issued and serviceable.

___ Nerve agent antidote is available and distributed (as required).

___ Convulsant antidote for nerve agent (CANA) is available and distributed (as required).

___ Decontamination apparatus is complete and serviceable.

___ Basic load of decontamination supplies is on hand (M291 skin DECON kits, M295 IEDK, DS2, and super tropical bleach [STB]).

___ Chemical agent alarms are on hand and serviceable.

___ M256A1 detector kits issued.

___ NBC contamination marking kits are distributed.

___ NBC teams are trained and briefed on the current threat and contingency plan.

___ Coordination for patient decontamination team support (nonmedical) is completed.

___ Patient protective wraps are on hand, if authorized.

___ Chemical agent monitors are on hand and serviceable.

___ M8 and M9 detector paper is on hand.

___ M272 detector kits are issued.

___ Replacement filters for protective masks are on hand.

___ Nerve agent pretreatment packets (NAPP) are available.

___ Biological agent prophylaxis/immunizations have been accomplished, if appropriate.

___ Radiac sets (AN/PDR 27, AN/PDR 77, or AN/VDR 2) are on hand.

___ Chemical agent patient treatment MES are on hand or available.

___ Chemical agent patient decontamination MES are on hand or available.

___ Biological sample collection equipment/supplies are available.

PRE-COMBAT CHECKLIST FOR MISCELLANEOUS EQUIPMENT

___ Inspect binoculars.

___ Inspect camouflage nets and support systems.

___ Inspect night vision devices.

___ Ensure batteries are on hand.

___ Inspect mine detectors.

___ Inspect tentage.

___ Inspect global positioning systems (if available).

PRE-COMBAT CHECKLIST OF PERSONNEL

___ Ensure soldiers are in the correct uniform.

___ Ask questions to ensure that soldiers have been briefed on mission and situation.

___ Implement appropriate MOPP level.

___ Check for drivers license.

___ Brief soldiers on operations safety and environmental injuries.

___ Individual equipment is on hand and stowed properly.

___ Soldier fed and briefed on future meal consumption.

___ Identification (ID) tags, ID card, multifunctional automated record card (MARC) are on hand and serviceable.

___ Camouflage self and equipment.

___ Work/rest plan implemented.

___ Water discipline plan implemented, if appropriate.

PRE-COMBAT CHECKLIST ON COMMUNICATIONS EQUIPMENT

___ Radios are operational (communications check conducted).

___ Telemedicine equipment is available and operational.

___ Speech security equipment functional.

___ Loaded, and one extra battery on hand.

___ Frequencies are set.

___ Matching units are operational.

___ Antennas tied down properly.

___ Connectors clean and serviceable.

___ TA-312 on hand and serviceable. Batteries are on hand.

___ WD-1 on hand and serviceable.

___ Manpack sets are complete, batteries are on hand.

___ Switchboard on hand and serviceable.

___ Antennas and remotes are present, batteries are on hand.

___ SOI is available and secured; call signs and frequencies have been disseminated.

___ Perform communications check again.

PRE-COMBAT CHECKS FOR VEHICLES

___ Loads are according to load plan; load plan posted in the vehicle.

___ Hazardous cargo properly identified and stored toward rear of vehicle for easy access and inspection.

___ Ammunition issued and properly stored.

___ Vehicle fuel tank topped off.

___ Package POL products and small arms lubricant present.

___ Water cans full.

___ MREs issued and stowed.

___ First aid kits present and complete.

___ Operators' manuals and lubrication orders are present for the vehicle, radios, and associated equipment.

___ Critical toll and basic issue items (BII) are present.

___ Vehicle dispatch is complete; DA Form 2404 is complete; no deadline deficiencies exist.

___ Before operation PMCS has been completed.

PRE-COMBAT CHECKLIST FOR INDIVIDUAL WEAPONS

___ Clean and functional.

___ Cleaning tools/kits, bolts, and ruptured cartridge extractors are present.

___ Range cards are on hand.

___ Ammunition is issued, accounted for, and secured.

___ Magazines issued.

___ Blank adapter installed (if appropriate).

___ Function check has been performed.

ANNEX J

REHEARSALS

REHEARSAL CHECKLIST

___ Company and individual platoons conduct rehearsals in four phases.
- ___ Phase I. Back brief to the commander prior to the issuance of the platoon order.
- ___ Phase II. All company leaders on a sand table. Each phase is discussed, including support to maneuver.
- ___ Phase III. Platoon rehearsals of the specific actions that are key to the success of the operation.
- ___ Phase IV. Company rehearsal, if time and space permits. Conduct mass casualty situation rehearsals within 24 hours of occupying a new operating site and twice weekly afterwards.

SUMMARY OF REHEARSAL CHECKLIST

___ Phase I. Company / Platoon back briefs.

___ Phase II. Sand table. Leaders discuss key actions by phase.

___ Phase III. Platoons rehearse specific actions.

___ Phase IV. Company rehearsal, if time and space permit.

ANNEX K

BRIEFING FORMATS

Once the OPORD is issued, the platoon leader may be required to brief the commander on what he understands the OPORD requirements to be. This ensures that the platoon leader understands what is expected of him and what the support requirements are and, provides the commander the opportunity to provide additional guidance, if required. (This procedure is sometimes referred to as a *briefback.)* The information consists of the—

___ Task organization.

___ Enemy situation.

___ Mission analysis.
- ___ Specified tasks.
- ___ Implied tasks.
- ___ Restrictions/constraints.

___ Key coordinating instructions.

___ Questions or assumptions required for planning.

Once the platoon leader determines how he will support the plan and prior to issuing that guidance to the platoon (platoon order), the platoon leader will brief the commander on what the platoon order will contain. (This process may be referred to as a *backbrief.)*

___ Task organization.

___ Enemy situation.

___ Mission analysis.
- ___ Specified tasks.
- ___ Implied tasks.
- ___ Restrictions/constraints.

___ Restated mission.

___ Concept (by phase).

___ Combat health support plan.

___ Key coordinating instructions.

ANNEX L

CONVOY PRE-COMBAT INSPECTIONS

CONVOY PRE-COMBAT INSPECTION CHECKLIST

NOTE: Medical units are normally a part of a CS or CSS convoy. Security for the convoy is provided for by nonmedical units/personnel.

___ Convoy commander issues a warning order.

___ Convoy members concurrently perform readiness, maintenance, and functional checks under supervision of leaders.
- ___ Weapons (distribution).
- ___ Vehicles (lights, license, BII, fuel levels, water, Class I).
- ___ Night vision devices (batteries functional).
- ___ Communications equipment (PMCS, frequency, backup plan).
- ___ Any special equipment (such as mine detectors).

___ Convoy leader makes a tentative plan.

___ Convoy leader issues his order.
- ___ Uses sand table or sketches.
- ___ Uses separate sand table or sketch of actions on contact.

___ Convoy leader or his designated representative conducts coordination for his mission.
- ___ Fire plan/scheme of maneuver.
- ___ Support requirements.
- ___ Current Intelligence update.
- ___ Control measures.
- ___ Command and signal.
- ___ Time schedule.
- ___ Combat health support en route.

___ Convoy leader supervises the mission preparation.
- ___ Key leaders backbrief the convoy commander.
- ___ Rehearsals are conducted for actions on contact, air attack, and actions at the release point.
- ___ Leaders—
  - ___ Supervise.
  - ___ Inspect.
  - ___ Ensure adequate security.
  - ___ Rehearse.

___ Convoy leader—
- ___ Monitors current situation.
- ___ Issues appropriate FRAGOs.
- ___ Executes actions or coordination resulting from change.
- ___ Remains current on positions and missions of higher, adjacent, and supporting units.

ANNEX M

CONVOY LEADER CHECKLIST

CONVOY CHECKLIST

___ Where is the start point? Release point?

___ What route is to be used? Alternate routes?

___ Has reconnaissance been made and condition of route determined?

___ Can bridges, tunnels, underpasses, and defiles safely accommodate all loaded vehicles?

___ Are critical points known and listed on strip maps for both primary and alternate routes?

___ What is the size of serials? How are the serials broken down?

___ What is the size of the march units? How are the march units broken down?

___ What is the rate of march? What speed will the pace vehicle travel at?

___ What is the vehicle interval on an open road? In built-up areas? At night? At halts?

___ What type of column will be used? Open (100 meter interval) and/or closed (50 meter interval)?

___ Have provisions been made for refueling, if required?

___ Has a suitable bivouac site been selected, if required?

___ Have suitable rest and field feeding halt areas been selected, if required?

___ Is road movement table needed? Prepared? Submitted?

___ Have convoy clearances been obtained? What date and time?

___ Is escort required and has it been requested?

___ Are spare vehicles available for emergencies?

___ Are vehicles fully serviced, lubricated, cleaned, and ready for loading?

___ Are loads balanced and in accordance with vehicle load plans?

___ Are drivers properly briefed? By whom? When? Strip maps furnished to drivers?

___ Is convoy marked front and rear of each march unit? Is each vehicle marked on sides and hood with convoy number, if required?

___ Are guides in place? Have arrangements been made to post guides and retrieve guides?

___ Are all lights to include blackout lights functioning properly?

___ Are maintenance services along the route alerted to convoy?

___ Is maintenance truck in rear of convoy?

___ Is there a plan for casualties treatment and evacuation?

___ Is higher headquarters informed of convoy estimated time of arrival (ETA)?

___ Is someone appointed in the rear of the convoy to take corrective action, such as to investigate accidents and unusual incidents? Who is the trail officer in charge?

___ Is there a plan for the upload of vehicles? Time, location?

___ Has a feeding plan been established? When, where, and what?

___ Has time been established for formation of convoy? Location? Order?

___ Are elements briefed on actions to be taken if enemy contact occurs?

___ Is the OPORD/road movement order on hand?

___ Has a weather forecast been obtained?

___ Do all personnel have proper clothing and equipment?

___ Is there a communications plan?

___ Are NBC alarms/detectors correctly positioned throughout convoy?

___ Has coordination for security for medical convoy been accomplished with the tactical force commander?

ANNEX N

CONVOY COMMANDER'S CHECKLIST

CONVOY COMMANDER'S CHECKLIST

___ Start point (SP).

___ Release point (RP).

___ Route (strip map).

___ Departure time.

___ Estimated time of arrival. Reconnaissance.

___ Convoy organization.
- ___ Size of march unit/serials.
- ___ Type of march.
- ___ Rate of march/convoy speed.
  - ___ Pace.
  - ___ Maximum speed.
  - ___ Maximum catch-up speed.
- ___ Operating gaps.
  - ___ Time gaps between march units/serials.
  - ___ Interval between vehicles.
  - ___ Open road.
  - ___ Towns and cities.
  - ___ At halts.

___ Convoy clearance.
- ___ Timely submission to proper agency.
- ___ Clearance number chalked on side of vehicles.
- ___ Clearance number removed on completion of march.
- ___ Vehicle markings.
  - ___ Convoy flags.
  - ___ Flashing warning lights on front and rear vehicles.

___ Rest halts.
- ___ Location.
- ___ Time and duration.
- ___ Refueling.

___ Loading.
- ___ Time and place.
- ___ Report to.
- ___ Type/class cargo.
- ___ Oversized loads.

___ Unloading.
- ___ Time and place.
- ___ Report to.

___ Driver briefing.
- ___ Responsibility.
- ___ Time and place.
- ___ Strip map and other route aids.

___ Vehicles.
- ___ Services.
- ___ Inspected.
- ___ Accident/breakdown procedures.
- ___ Communications checks (frequencies).
- ___ Properly dispatched.
- ___ Vehicle on vehicle materiel/highway warning kits.

___ Drivers.
- ___ Qualified/valid Standard Form (SF) 46.
- ___ Proper uniform.
- ___ Strip map issued.
- ___ Briefed.

___ Cargo.
- ___ Properly loaded and secured/protected from weather.

___ Security measures.
- ___ En route.
- ___ At halts.

___ Trail.
- ___ Wrecker.
- ___ Combat health support.

___ Guides.
- ___ Position.
- ___ Posting and pickup.

___ Military/civil police support.

___ Points of contact along route for CHS and maintenance.

___ Use of lights.
- ___ During operation.
- ___ Blackout restrictions.

___ Release of trucks.
- ___ Time.
- ___ Responsibility.

___ Debriefing and after-action review.
- ___ Responsibility.
- ___ Time and place.

ANNEX O

CONVOY COMMANDER'S BRIEFING CHECKLIST

SITUATION

___ Friendly forces

___ Supported units

___ Enemy situation

MISSION

___ Origin

___ Destination

EXECUTION

___ General organization of the convoy

___ Time Schedule

___ Routes

___ Convoy speed

___ Catch-up speed

___ Vehicle distance (interval)

___ Location and time of rest/meal halts

___ Emergency measures
- ___ Breakdown and accident notification/control measures
- ___ Use of highway warning kits
- ___ Separation from convoy
- ___ Ambush
  - ___ Action of convoy personnel
  - ___ Action of security personnel

___ Combat health support

ADMINISTRATION AND LOGISTICS

___ Control measures

___ Uniform of personnel

___ Billeting arrangements

___ Messing arrangements

___ Refueling of vehicles

___ Servicing of vehicles

SAFETY

___ Hazards of route and weather conditions

___ Defensive driving principles

___ Compliance with civil traffic regulations

___ Obedience to civil and military police escorts

___ Critical points along route (specify actions to take)

___ Seat belt will be worn at all times while operating or riding in a vehicle equipped with seat belts

COMMAND AND SIGNAL

___ Location of convoy commander

___ Designation and location of assistant convoy commander

___ Actions of security forces commander

___ March unit/serial commander responsibilities

___ Arm and hand signals

___ Other signals

___ Radio frequencies and call signs for--
- ___ Control personnel
- ___ Security forces commander
- ___ Medical evacuation support

ANNEX P

COMMAND POST OPERATIONS

The command post (CP) is the medical unit commander's principal facility for the C^2 of unit CHS operations.

GENERAL

___ CP established and staffed by company headquarters.

___ XO ensures CP's smooth operation and commander's ability to track required information.

CP's PURPOSE

___ Receive, analyze, disseminate information critical to success of the unit mission.

___ Use journal, situation map, informational displays.

JOURNAL

___ Official chronological record of events of a unit or staff section during a period of time.

___ Always maintain journal unless otherwise directed by the commander.

___ Maintain journal on DA Form 1594.
- ___ Make entries legible.
- ___ Be concise.
- ___ Ensure "ACTION" column records actions taken.
  (**NOTE: DO NOT write "logged" as a description of action.)**

SITUATIONAL MAP

___ Graphic presentation of current situation.

___ Minimum overlays on the map include—
- ___ Operations.
- ___ Obstacles.
- ___ Combat service support (CSS).
- ___ Combat health support (such as treatment facilities, evacuation assets/points, or Class VIII points).
- ___ Symbols on map will be according to FM 101-5-1.

___ XO and HQ platoon sergeant ensure all overlays remain up to date.

INFORMATIONAL DISPLAY

Informational display in form of a chart reflecting information such as—
- ___ Task organization.
- ___ Mission.
- ___ Intent.
- ___ Operations sketch.
- ___ Weather and light data.

___ Personnel status.
___ Equipment status
___ Medical evacuation status.
___ Class VIII status.
___ Sensitive items.
___ Communications status.
___ CHS locations.
___ Other information as the commander directs.

IMPORTANCE OF JOURNAL, SITUATIONAL MAP, AND INFORMATIONAL DISPLAY

___ Remember the effect of the information from these three sources on the success of the operation.

___ Information mindlessly recorded or annotated **DOES NOT** provide assistance.

___ Think outside the box.

STAFFING

___ Man the CP 24 hours per day.

___ Ensure minimum of two personnel in CP at all times.

___ Uniform inside the CP is battle dress uniform (BDU) and protective mask; ground all other equipment.

___ Eating not permitted in the CP.

___ Members of the HQ platoon secure chow for those on shift and ensure that they are permitted time to eat.

POLICE

___ Maintain CP in a high state of police.

___ Ensure table tops are cleared unless being worked on.

___ Clear area immediately when work is completed.

___ Each shift ensures all areas are cleared.

___ Each shift reports supplies used to the supply sergeant.

MISCELLANEOUS

___ Ground personal gear along the side wall of the CP.

___ Clear and store weapons in the weapons rack.

___ Place sensitive items on the top of the rack.

ANNEX Q

SITE SELECTION AND ESTABLISHING THE COMPANY AREA

SITE SELECTION CONSIDERATIONS CHECKLIST

___ Coordinate site selection and receive approval from the appropriate headquarters.

___ Anticipated length of occupancy of the location.

___ Accessibility for ground and air evacuation platforms (near major road networks, accessible from different directions).

___ Away from lucrative military targets.

___ Near expected areas of patient density.

___ Is the site large enough to permit dispersal of the unit and afford sufficient room for ambulance turnaround, patient decontamination operations, and augmentation/reinforcement?

___ Does the site selected provide good hardstand and drainage?

___ What is the impact of the site on communications equipment/capabilities?

___ How much cover and concealment does the site provide?

___ Is there sufficient space for a landing zone? Is there sufficient space downwind of the unit area to establish a landing zone for contaminated aircraft?

___ Is the site easily defensible?

ESTABLISH THE COMPANY AREA CHECKLIST

___ Company commander finalizes the external layout plan.
- ___ Determine a traffic pattern which facilitates the movement of vehicles and equipment and avoids cross-traffic intersections.
- ___ Identify an ambulance turnaround point.
- ___ Identify helicopter landing zones (conventional and NBC contaminated) which avoid takeoffs and landings over the established company areas.
- ___ Determine location of field sanitation facilities (latrines, handwashing facilities, and waste disposal).
- ___ Determine location of temporary morgue holding area out of the sight of the treatment area, if required.
- ___ Determine location for patient decontamination operations, down wind from company area.

___ Company commander finalizes the internal layout plan.
- ___ Determine a traffic pattern which facilitates the movement of vehicles, equipment, and patients.
- ___ Adjust the location of operating sections to improve the work flow or security.
- ___ Supervise the displacement of squads/teams to forward supported units

___ Treatment platoon sets up AO.
- ___ Establish ambulance turnaround point.
- ___ Establish communications with company switchboard.
- ___ Employ power generation equipment.
- ___ Set up platoon bivouac area.
- ___ Prepare treatment squads for forward deployment, if required.
- ___ Position supplies and equipment in accordance with layout plan.
- ___ Protect supplies and equipment.
- ___ Establish triage area.
- ___ Set up areas for treatment squads in accordance with layout plan.
- ___ Set up area for dental and laboratory services, if applicable.
- ___ Set up area for x-ray services; ensure radiation safety area is clearly marked.
- ___ Set up medical equipment.
- ___ Set up dental, laboratory, and x-ray equipment, if applicable.
- ___ Check equipment for serviceability and update calibration in accordance with appropriate technical manuals or manufacturer's instructions.
- ___ Establish patient holding area.
- ___ Camouflage area, when directed by appropriate authority.
- ___ Report to company CP when area is operational.
- ___ Designate area for patient decontamination operations, if required.

___ Ambulance platoon sets up AO.
- ___ Establish landing zone in accordance with layout plan.
- ___ Position ambulances. Ensure first up ambulance is prepared for dispatch.
- ___ Ensure medical equipment set is complete.
- ___ Perform PMCS on ambulances and equipment.
- ___ Coordinate communications with supported units.
- ___ Field site ambulances with supported units, when required.
- ___ Coordinate for AXPs, as required.
- ___ Establish platoon bivouac area.
- ___ Camouflage area when directed by appropriate authority.

___ Headquarters platoon sets up AO.
- ___ Communications specialist establishes wire and FM communications.
- ___ Set up company CP according to the layout plan.
- ___ Set up medical and unit supply according to the layout plan.

ANNEX R

PRIORITIES OF WORK

PRIORITIES OF WORK CHECKLIST

NLT TIME		ACTION	AGENT
NLT O+1	___	Establish perimeter, provide security	All
	___	Cover/concealment of vehicles and equipment	All
	___	First up ambulance is mission ready	AMB PLT
	___	Send out LP/OP	SEL PLT
	___	CDR/1SG position weapons	CDR/1SG
	___	LDRs coordinate with adjacent platoons	PLT LDRs
	___	CDR assigns platoon sectors	CDR
	___	CO HQ lays wire to BN TOC	COMMO
	___	Sections lay wire to CO TOC	PLTs
	___	All land line nets are up	COMMO
	___	Limited treatment capability achieved	TRMT PLT
	___	Emplace M-8 alarms 150m upwind of CO	NBC
	___	LZ identified	AMB PLT
NLT O+2	___	OE-254S emplaced/FM, land line, and DNVT up	COMMO
NLT O+3	___	Company CP established	HQ PLT
	___	LZ established, grid reported to CP and BN TOC	AMB PLT
	___	Operations area established	TRMT PLT
		Priority is:	
		___ Triage area.	
		___ Treatment area	
		___ Pnt decon area	
		___ Pnt holding X-ray/Lab area	
		___ Dental area	
NLT O+4	___	CDR assigns sectors of fire	CDR
	___	Construct fighting positions	PLTs
	___	Prepare range card/emplace sector stakes	PLTs
	___	Prepare obstacles and early warning devices	PLTs
	___	Turn in initial sector sketches to the CO CP	PLTs
NLT 0+6	___	NBC harden the company area	NBC
	___	Turn in updated sector sketches	PLTs
NLT 0+8	___	Company 100% established and operational	CDR
	___	Establish sleep area/begin sleep plan	1SG
	___	Notify BN TOC of MASCAL rehearsal time	TRMT/CDR
	___	Identify assembly areas	CDR
	___	Establish and inspect field sanitation points	FS TM LDR
	___	Conduct route reconnaissance, if required	AMB PLT LDR

ANNEX S

DEFEND ASSIGNED AREA CHECKLIST

DEFEND ASSIGNED AREA CHECKLIST

___ *Positioning.*
- ___ Place defensive perimeter inside a woodline to maximize cover and concealment.
- ___ Place a section perimeter at least 35 meters (hand grenade range) from its vehicles and sleep areas.

___ *Fighting Positions.*
- ___ Arrange fighting positions normally in a "Lazy W" configuration.
- ___ Arrange so that positions are mutually supporting. *(A direct attack on a single fighting position must be able to be supported by direct fire from two other positions.)*
- ___ Ensure distance between positions makes maximum use of terrain for dispersion.
- ___ Locate positions outside of hand grenade range of one another.
- ___ Stagger positions alternately along the perimeter to achieve depth in the "Lazy W."

___ *Range Cards.*
- ___ Prepare range cards for each primary and alternate position.
- ___ Place range cards by the firing stakes unless the position is not manned at that time.

___ *Section Sector Sketch*.
- ___ The platoon leader's section sketch includes—
  - ___ All individual positions identified by individual.
  - ___ All dead space to their front.
  - ___ LP/OP positions.
  - ___ Wire and obstacles.
  - ___ Adjacent section positions to left and right.
  - ___ Supplementary positions.
- ___ Each platoon will:
  - ___ Turn-in initial sector sketches within one hour of arrival.
  - ___ Update as required by priorities of work.

___ *Wire Obstacles.*
- ___ *Tactical wire.*
  - ___ Place tactical wire in section sectors for a minimum of 50 meters.
  - ___ Ensure tactical wire consists of triple strand concertina wire with a single strand of barbed wire run along the top row of wire and another anchoring the base of the friendly side.
  - ___ Hang concertina wire on long pickets tied together with communications wire to avoid breaks.
  - ___ Anchor wire on each end by a short picket.
- ___ *Protective Wire.*
  - ___ String protective wire in front of individual fighting positions.
  - ___ String protective wire outside hand grenade range of positions not less than 35 meters to the front.

___ *Techniques.*
- ___ Start tactical wire 25-30 meters from the muzzle of the weapon.
- ___ Lay in tactical wire with a stake string tied to the muzzle of the weapon.
- ___ Use wire obstacle to confuse the enemy as well as stop, impede, or canalize the enemy's force.
- ___ Place single strand concertina wire/barbed wire between trees.
- ___ Improve the wire/barbed wire later with tangle foot.

___ *Work Considerations*.
- ___ Keep troops in uniform.
- ___ One soldier works; one rests or provides security.
- ___ Ensure troops keep personal gear/weapons within reach at all times.
- ___ Conceal range cards and other relative object.
- ___ Maintain effective light discipline.

STAND TO CHECKLIST

___ NLT ____, the on-shift duty section will awaken the Food Service Sergeant.

___ Food Service SGT will awaken food service personnel.

___ Food Service section will have meal prepared and ready to serve NLT 0630.

___ Hot water for soldiers use during personal hygiene time will be prepared by food service section and ready for use NLT 0600.

___ The duty section will awaken all officers/senior NCOs; senior NCOs will awaken all soldiers maintaining strict noise and light discipline. Generators will be turned off.

___ Personnel occupy defensive positions. Radios/land communications are monitored. Plt Ldr/SGTs check all positions and obstacles in sector. Section leaders/NCOs will report personnel and equipment accountability status to unit commander/1SG upon completion of Stand To.

___ Operators/assistant operators and supervisors perform PMCS using appropriate -10 series manuals on vehicles, weapons, generators, and communications equipment. Vehicle headlights and windshields will be cleaned.

___ Operator completes DA Form 2404 (as a minimum, the date and driver's initials will be entered if no faults are found). Uncorrectable faults will be noted on the DA Form 2404 at this time.

___ DA Form 2404 showing corrected faults (if any) will be given to the company maintenance sergeant by section NCOs.

___ Company maintenance sections will spot check vehicles to ensure that maintenance is being performed and lend assistance if appropriate.

___ After PMCS is performed, start all engines immediately, if necessary.

___ Recommended time for completion of Stand To activities.

ANNEX T

MEDICAL EVACUATION

DEFINITION OF TERMS

Casualty--Any person who is lost to his organization by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing, missing in action, beleaguered, besieged, or detained.

Casualty Evacuation (CASEVAC)--the movement of sick, injured, or wounded soldiers by nonmedical vehicles to a medical treatment facility. The casualty receives no medical care en route. It may also be referred to as *casualty transportation.*

Medical Evacuation (MEDEVAC)--the movement of sick, injured, or wounded soldiers in medical vehicles with the provision of **en route medical care** to a medical treatment facility.

Patient--A sick, injured, or wounded soldier who receives medical care or treatment from medically trained personnel. (**NOTE**: Once a casualty has been acquired by the CHS chain [treated by a medic], he is referred to as a *patient*.)

EVACUATION CHECKLIST

___ Consider these factors with METT-T when planning patient evacuation:
- ___ The brigade's plan for employment of combat troops.
- ___ Expected areas of patient density.
- ___ Evacuation resources available.
- ___ Location and type of MTFs available terrain and road networks.
- ___ Weather conditions.
- ___ Location of patient collecting points.
- ___ Location of AXPs.
- ___ Primary and alternate routes of evacuation.
- ___ Lines of patient drift.

___ The primary means of evacuation is by ground ambulance. The preferred means of evacuation is by air ambulance when corps assets are available.

___ Evacuate patients by the mode of transportation which most nearly meets the treatment demands of their wound.
- ___ Remember the METT-T restrictions.
- ___ Move patient no further to the rear than is necessary to obtain the medical care which will return them to duty.
- ___ Determine the patient's disposition by the treating element.

___ The medical company is responsible for evacuating from the combat team's medical platoons (battalion aid stations).
- ___ The key to successful evacuation is the medical company remaining in proximity of and maintaining communications with it's supported elements.

___ Ambulances will normally be prepositioned forward to facilitate rapid evacuation based on METT-T.

___ Army Medical Department (AMEDD) aircraft and ground ambulances will only be used for the movement of patients, medical personnel, and medical supplies and equipment.

___ All medical units will monitor and conduct medical evacuation using the division designated medical evacuation frequency. This frequency will be published in the OPLAN\OPORD.

___ Priority of evacuation/medical care will always be conducted according to triage category regardless of patient origin.

___ Prior to all operations, establish and rehearse an evacuation plan that includes the following at a minimum:
- ___ Primary and alternate channels to be used in submitting MEDEVAC requests.
- ___ Primary and alternate routes.
- ___ Evacuation platforms available.
- ___ Location of all MTFs and their capabilities.
- ___ Actions and assets available in the event of a mass casualty situation.

___ Evacuation categories.

URGENT. Is assigned to emergency cases that should be evacuated as soon as possible and within a maximum of 2 hours to save life, limb, or eyesight and to prevent complications of serious illness, or to avoid permanent disability.

URGENT SURGICAL. Is assigned to patients who must receive far forward surgical intervention to save life and stabilize for further evacuation.

PRIORITY. Is assigned to sick and wounded personnel requiring prompt medical care. This precedence is used when the individual should be evacuated within 4 hours or his medical condition could deteriorate to such a degree that he will become an URGENT precedence, or whose requirements for special treatment are not available locally, or who will suffer unnecessary pain or disability.

ROUTINE. Is assigned to sick and wounded personnel requiring evacuation but whose condition is not expected to deteriorate significantly. The sick and wounded in this category should be evacuated within 24 hours.

CONVENIENCE. Is assigned to patients for whom evacuation by medical vehicle is a matter of convenience rather than necessity.

___ MEDEVAC requests.
- ___ Submit by the most direct means available to the supporting medical unit.
- ___ Submit using the nine-line format and brevity codes as required in FM 8-10-6.
- ___ Submit by secure means and/or encrypt..

___ Evacuation in an immature theater.
- ___ May have to be accomplished by C-130 backhaul to the CONUS.
- ___ Coordinate aircraft through the brigade aeromedical evacuation liaison team (AELT).
- ___ Prepare DD Form 601, Patient Evacuation Manifest, and DD Form 602, Patient Evacuation Tag.
  - ___ The treatment platoon is responsible for procuring, stocking, and completing these forms.
  - ___ Keep one copy of DD Form 601 and DD Form 602 on file with the MTF.
  - ___ Complete these forms IAW FM 8-10-6.

ANNEX U

MEDICAL EVACUATION SUPPORT PLAN CHECKLIST

MEDICAL EVACUATION SUPPORT CHECKLIST

___ Evaluation of COA's prior decision.

___ Mission statement/commander's intent/task organization.

___ IPB considerations.

___ Casualty estimates (by company phase).

___ Location of:
- ___ Platoon patient collecting points. (PCPs)
- ___ Company PCP.
- ___ BAS: Trmt TM 1/Trmt TM 2.
- ___ AXP.
- ___ FSMC/MSMC.

___ Evacuation routes.
- ___ Primary and alternate.
- ___ Trafficability (condition, obstacles, overhangs).
- ___ Security.
- ___ Strip maps.
- ___ Overlays

___ LZs designated for air ambulances.

___ Platoon/Company/TF litter teams designated.
- ___ Collocated with PCPs.
- ___ Type of litter (NATO standard, SKED).

___ Evacuation assets available (requested/prepositioned)
- ___ Ground ambulance (2 & 4 litters).
- ___ Nonmedical transportation vehicles.
- ___ Aircraft (UH-1/UH-60A/CH-47)

___ Medical evacuation support plan for units without CHS resources.
- ___ Combat lifesavers.
- ___ Augmentation requested from FSMC/MSMC.
- ___ Evacuation.
- ___ Personnel.
- ___ Equipment.
- ___ Other.

___ Mass casualty plan (resourced/rehearsed/coordinated).
- ___ Litter bearers.
- ___ Combat lifesavers.
- ___ Vehicles.
- ___ Class VIII (medical supplies).

___ Class VIII resupply (prepackaged)
- ___ Combat lifesaver.
- ___ Combat medic.
- ___ BAS.

___ Communications (Call sign/frequency).
- ___ Company/battalion command net.
- ___ FSB & FSMC command net.

___ Personal effects, weapons, equipment & property exchange.

___ NBC casualty plan.
- ___ Location of decontamination site.
- ___ Personnel augmentation.

___ Enemy personnel casualty plan.

MEDEVAC REQUEST FORMAT

LINE	ITEM	BREVITY CODES
1	LOCATION OF PICKUP SITE	
2	FREQUENCY/CALL SIGN OF PICKUP SITE	
3	NUMBER OF PATIENTS BY PRECEDENCE	A - URGENT B - URGENT SURG C - PRIORITY D - ROUTINE E - CONVENIENCE
4	SPECIAL EQUIPMENT	A - NONE B - HOIST C - EXTRACTION D - VENTILATOR
5	NUMBER OF PATIENTS BY TYPE	L + # LITTER A + # AMBULATORY
6	SECURITY OF PICKUP SITE	N - NO ENEMY P - POSSIBLE ENEMY E - ENEMY IN AREA X - ARMED ESCORT NEEDED
7	METHOD OF MARKING PICKUP SITE	A - PANELS B - PYROTECHNICS C - SMOKE D - NONE E - OTHER
8	PNT NATIONALITY AND STATUS	A - US MILITARY B - US CIVILIAN C - NON US MILITARY D - NON US CIVILIAN E - EPW
9	NBC CONTAMINATION	N - NUCLEAR B - BIOLOGICAL C - CHEMICAL

ESTABLISH BATTALION PATIENT COLLECTING POINT

___ Site Selection.
Ensure that the site selection is:
- ___ Easily secured.
- ___ Known by all soldiers.
- ___ Near friendly routes of movement.
- ___ Area protected from enemy by friendly forces.
- ___ Provided with the means for cover and concealment.
- ___ Spacious enough to contain casualties.
- ___ Building of opportunity (MOUT [school, hangar, theater]).
- ___ Communication capable.
- ___ **NOTE: Select an alternate site.**

___ Manage PCP Operations, if site is manned..

BATTALION PCP COMBAT CONSIDERATIONS IN MEDICAL EVACUATION CHECKLIST

___ Plan for employment of combat forces (tactical commanders).

___ Know anticipated patient load.

___ Know expected areas of patient density.

___ Plan for patient conditions.

___ Know availability of medical evacuation resources.

___ Know location and type of medical treatment facilities available.

___ Be familiar with road/route network.

___ Be aware of probable weather conditions.

MEDICAL RESPONSIBILITIES ON THE BATTLE FIELD CHECKLIST

___ Maintain radio contact with the BN PCP.

___ Find and collect the wounded.

___ Perform triage when necessary.

___ Administer EMT.

___ Initiate or complete the US Field Medical Card (FMC).

___ Evacuate casualties to the BN CCP.

___ Direct or guide ambulatory patients to the BN CCP.

___ Resupply company medics with Class VIII supplies.

ANNEX V

EVACUATION CAPABILITIES

	LITTER	AMBULATORY
USAF		
TRANSPORT AIRCRAFT		
C-130 HERCULES##	70	85
C-9A NIGHTINGALE*	40	40
combination of 15 litter and 24 ambulatory		
C-141B STARLIFTER##	103	147
C-5 GALAXY##		70
C-17A##		48 plus 44 ambulatory
CIVIL RESERVE AIR FLEET (CRAF)		
BOEING 767 (B-767)	111**	
US ARMY		
Ground vehicles		
M886/893 TRUCK, AMBULANCE*	4	8
M1010 TRUCK, AMBULANCE*	4	8
BUS, MOTOR, 44 PASSENGER*	18	37
M113 CARRIER, AMBULANCE*	4	10
(**CAUTION**: Spall liner must be removed.)		
M880/890 AND M1008 TRUCK	5	8
M996TRUCK, HMMWV		
AMBULANCE (MINI-NONEXPANDED)*	2	0
M996 TRUCK HMMWV AMBULANCE		
(MINI EXPANDED)*	2	6
TRUCK CARGO 2 ½ TON, 5 TON*	12	16
M997 TRUCK HMMWV AMBULANCE (MAXI)*	4	8
M998 TRUCK, CARGO/TROOP CARRIER	3	5
Fixed-Wing Aircraft		
U-21 UTE	3	10
C-12 HURON		8
Rotary-Wing Aircraft		
CH-47D CHINOOK	24	33
UH-60A/Q BLACKHAWK	6 + 1 ambulatory	7#
UH-1H/V IROQUOIS	6	9
Rail Transport		
Pullman Car (US)	32	48
US Army Rail Transport (Continued)		
SLEEPING CAR (NATO/HOST		
NATION SUPPORT	32	48
AMBULANCE RAILWAY CAR		
(NATO/HOST NATION SUPPORT)	24	30
AMBULANCE RAILWAY CAR,		
PERSONNEL	21	21
RAIL BUS	40 + 16 ambulatory	

	LITTER	AMBULATORY
US NAVY		
Ships and watercraft		
T-AH 19, USNS MERCY	1000###	1000###
T-AH 20, USNS COMFORT	1000###	1000###
AMPHIBIOUS ASSAULT SHIP (LHD)(MULTIPURPOSE)##, ###, &, && (Casualty receiving ship (CRTS) (Receives both helicopter and waterborne casualties)	604	604
AMPHIBIOUS ASSAULT SHIP (LHA) (GENERAL PURPOSE)## ### (Receives both helicopter and waterborne casualties)	367	367
AMPHIBIOUS ASSAULT SHIP (LPH)(Helicopter) (CRTS)##, ###, &, &&	222	222
AMPHIBIOUS TRANSPORT DOCK (LPD) ## (Could be designated as an emergency or overflow CRTS)	14	14
DOCK LANDING SHIP (LSD) ## ### (Only newer LSDS (Class 41 and newer ships) have limited for use as emergency or overflow CRTS. They do not have dental capability.)	108	108
AMPHIBIOUS CARGO SHIP (LKA) ## (Medical officer assigned. Could support fleet surgical team (21 person medical augmentation team). The number of potential patient care beds are limited. Not suitable as CRTS. No dental capability.)	12	12

	LITTER	AMBULATORY
TANK LANDING SHIP (LST) (Extremely limted medical capability and no dental capability. The large tank deck [designated for vehicle stowage] offers potential use as a casualty treatment space if an appropriate shelter is installed. The obvious advantage is in its ability to reach the beach. Elements of a fleet surgical team could be used to provide personnel and equipment for this potential use. Used in mass casualty situations.)		
AMPHIBIOUS COMMAND SHIP (LCC) (The LCC has adequate medical facilities to care for embarked personnel. Its mission and limited bed capacity preclude its use as a CRTS. The amphibious task force surgeon, landing force surgeon, and other key medical staff officers are normally located on an LCC during operations.	24	24
Rotary-wing aircraft		
CH-46 SEA KNIGHT**	15	25
CH-53D SEA STALLION**	24	55 with center line seating installed
V-22 OSPREY	12	24

LEGEND

- * Requires onboard medical attendants and equipment.
- ** Configured for litter patients only.
- *** Maximum capacity litter or ambulatory.
- # Ambulatory patient figure for UH-60A is 15 if litter kit is not installed.
- ## Naval vessels and aircraft and USAF cargo aircraft in most situations require on board medical attendants and equipment.
- ### Figures for litter and ambulatory patients are the same since all patients require a bunk.
- & These capacities require any Marines on board to be disembarked to shore.
- && These capacities will require Navy personnel augmentation packages (similar to PROFIS) on board. The majority of each of these capacities consists of overflow beds.

ANNEX W

Landing Zone Operations

LZ OPERATIONS CHECKLIST

___ **General**
- ___ Operate all field expedient landing zones IAW FM 8-10-6.
- ___ The ambulance platoon:
  - ___ Proponent within the company for aeromedical evacuation.
  - ___ Tasked to establish and operate the medical company LZ.
  - ___ Headquarters element should be prepared to assist.

___ **Safety**
- ___ At all times take all necessary safety precautions.
- ___ The ambulance platoon is responsible for providing all safety gear required to run an LZ. Included are:
  - ___ Safety goggles.
  - ___ VS-17 panels.
  - ___ Chemical lights.
  - ___ Smoke.

___ **Marking the LZ**
- ___ Use an inverted "Y" to mark the LZ.
- ___ During daylight, camouflage the LZ so the VS-17 panels can't be seen from the air.
- ___ At night, emplace chemical lights only when an air ambulance is confirmed as inbound.

___ **Landing requirement for light helicopters**
- ___ Minimum real estate required is a cleared area 30 meters in diameter.
- ___ Area must have an approach and departure zone clear of obstructions and not over the established company area.

ANNEX X

Mass Casualty Operations

MASCAL OPERATIONS CHECKLIST

___ A MASCAL exists any time the patient load exceeds the treatment or evacuation capabilities of a unit.

___ Upon notification of a MASCAL, the medical company commander will immediately assess the situation to determine what support is required.

___ The medical company commander will then notify the battalion TOC and identify to them the required support. If required, the CHSO will notify the brigade if support requirements exceed that of the BSA.

___ The medical company commander will then notify the DMOC to ensure that they are aware of the situation and can assist in shifting assets, if required.

PLANNING CONSIDERATIONS

___ Planning considerations for MASCAL situations include but are not limited to:
- ___ Establishing a control element to control all activities and provide informational updates. Normally conducted by the MED CO CP.
- ___ Securing the area and limiting access to essential medical personnel.
- ___ Establishing triage, treatment, and holding areas. Might not be at the medical company. May require forward positioning.
- ___ Marking routes for vehicles.
- ___ Orienting all personnel working in the MTF on stations. Markings and requirements to be accomplished during the MASCAL.
- ___ Organizing medical and non-medical personnel for staffing of the different areas.
- ___ Ensuring an adequate blood supply and/or other class VIII items are available.

SUPPORT

___ The CHSO will assist the medical company commander in requesting all necessary support. The BSA commander will support the MASCAL with the following support:
- ___ Litter teams from the BSA tenant units.
- ___ Security for ground ambulances.
  Provided by the MP platoon., chemical platoon, or internal BSA assets.
- ___ Non-standard evacuation platforms such as 5 tons, HMMWVS, or other vehicles as required for patient evacuation.
  The medical company will normally have 3 5 ton vehicles already prepared for the event.

THE BSA COMMANDER

___ The BSA commander will assist in procuring BSA external support as required.
- ___ Aeromedical evacuation platforms as well as non-standard air platforms will be utilized to their fullest extent possible.
- ___ Gunship escorts for the air platforms must also be arranged.

TRIAGE

___ Patients will be triaged into one of four treatment categories.
This will normally be conducted by the dental officer (marked w/blue chemlight at night).

___ To ease a non-medical person's ability to recognize these categories, coded signs will be utilized.

___ During the hours of darkness, colored chemlights will be utilized.

___ During daylight hours, the first letter of each word will be shown on a plywood sign.

IMMEDIATE	=	1	=	BLUE
DELAYED	=	D	=	YELLOW
MINIMAL	=	M	=	WHITE
EXPECTANT	=	E	=	GREEN

___ Each of the treatment category stations will have a medic in charge of that station to provide care to those soldiers until they are treated by a physician.

PERSONNEL

___ Two personnel pools will be established, one for medical and one for nonmedical personnel.

___ All personnel will be marked to aid identification during the MASCAL.

___ Medical personnel will wear the Red Cross brassard on their left sleeve.

___ Nonmedical personnel will wear white engineer tape on their left sleeve and will write their duty position on it (i.e., litter bearer, messenger, etc.).

___ Someone will be placed in charge of the two areas to ensure the work-rest cycle is enforced and all stations are adequately manned.

___ Patients triaged into the minimal category should be used to the fullest extent possible to act as messengers, litter bearers, or guides. This ensures that all medical personnel are freed to perform medical tasks.

PATIENT ACCOUNTABILITY

___ Patient accountability is critical during a MASCAL.

___ If the patient load exceeds the medical companies' ability to adequately log all incoming casualties, a number system will be used.

___ Casualties will be identified by a number.

___ That identification number will be recorded on the FMC and all treatment and medications will be recorded on the FMC.

___ As the MASCAL begins to resolve, all required information can be obtained, and proper accountability can be regained.

___ At no time, will a casualty be evacuated from the medical company without the following information being known:
- ___ Name.
- ___ Rank.
- ___ SSN.
- ___ Unit.
- ___ Diagnosis.
- ___ Destination.
- ___ Evacuation category.

EQUIPMENT ACCOUNTABILITY

___ When the medical company is notified what units are involved in the MASCAL, those units who are operation in the BSA will be notified.

___ These units will send an S1 representative and an S4 representative to assist in personnel and equipment accountability.

___ All equipment accountability will be headed up by the medical company headquarters element.

___ All equipment will be tagged and returned to the casualty's unit's field trains.

CONTAMINATED PATIENTS

___ All initial triage, EMT, and decontamination will be accomplished on the dirty side of the hot line.

___ Life sustaining care will be provided regardless of NBC contamination.

___ Secondary triage, ATM, and patient disposition are accomplished on the clean side of the hot line.

DISPOSITION OF REMAINS

___ If required, a temporary morgue will be established by the medical company.

___ This is only to be used by the medical company to hold those casualties who are DOA to the MTF or DOW.

___ This temporary morgue will be established out of sight of all triage and treatment areas.

___ If possible, the area will be established behind a natural barrier. This only a holding area.

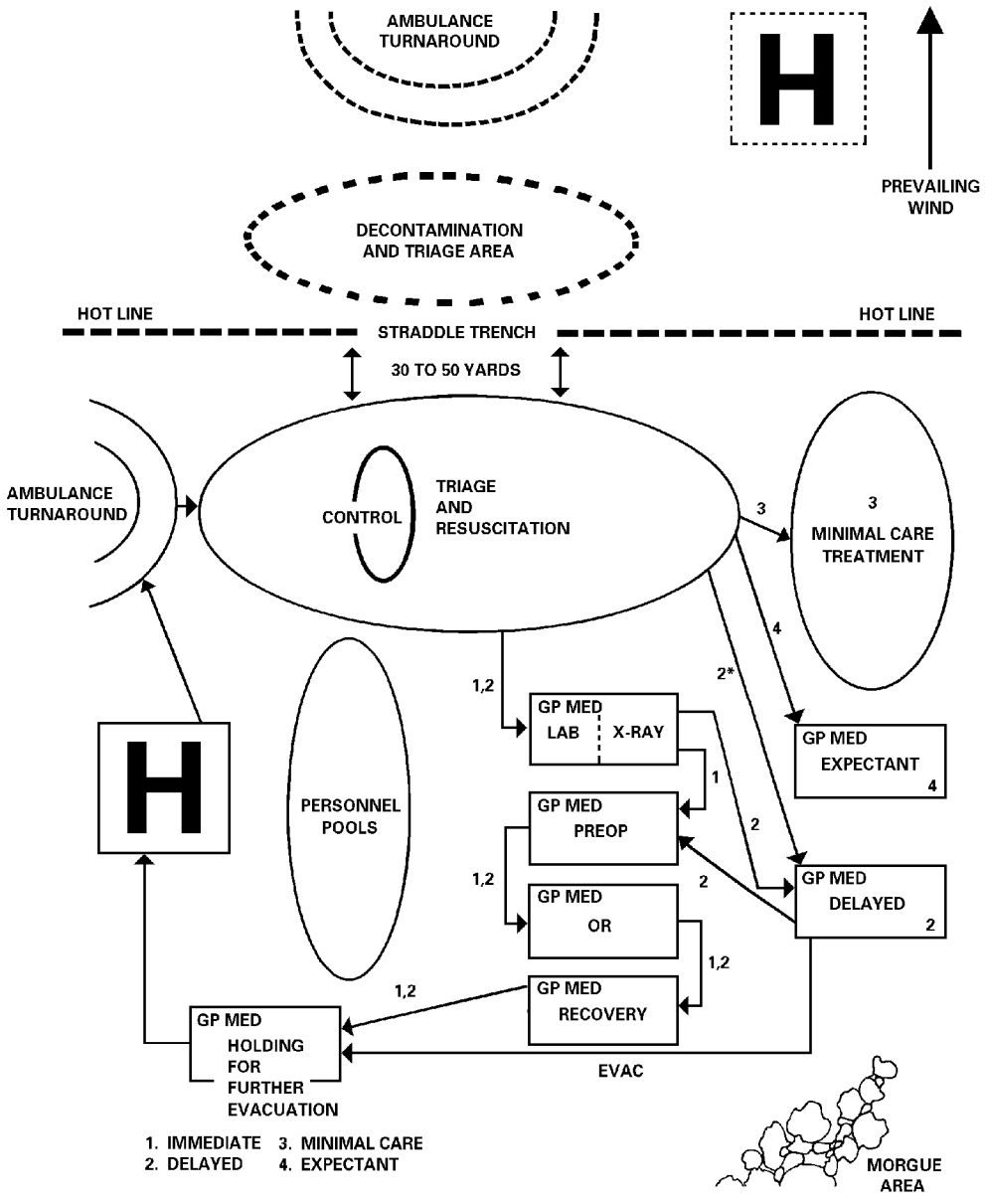
___ The FMC must still be completed by a physician. Remains will be held until mortuary affairs (MA) is notified and secures the remains.

REHEARSALS

___ The response to the MASCAL situation must be rehearsed.

___ Conducting rehearsals will ensure that all personnel are clear on what their duties entail and what their actions are.

___ Rehearsals will be conducted within 24 hours of occupying a new operating site and twice weekly afterwards.



*THE DELAY CATEGORY PATIENT MAY NOT REQUIRE LABORATORY AND/OR X-RAY PROCEDURES

ANNEX Y

COLD WEATHER INJURIES

Although medical personnel are more familiar with the signs and symptoms of cold injuries than soldiers without a medical background, it is still imperative that medical unit leaders stress cold injury prevention and field expedient techniques for managing cold injuries in the field.

___ Protect soldier health through informed leadership.

___ Know current temperature, wind chill factor; plan accordingly.

___ Enforce cold injury prevention.

___ Observe soldiers with history of cold injury.

___ Conduct cold injury prevention training annually.

___ Ensure all soldiers have adequate cold weather clothing.

RECOGNITION OF COLD INJURIES

___ General hypothermia—caused by prolonged cold exposure, fatigue, and exhaustion—resulting in rapid loss of body heat.

___ Non-freezing cold injuries—associated with exposure to water or damp conditions and cold temperatures.
- — Chilblain . . . . . intermittent exposure to high humidity and temperatures above freezing.
- — Immersion foot . exposure greater than 12 hours in water above 50° F.
- — Trench foot . . . . exposure to cold and wetness from just above freezing to 50° F.
- — Frostbite . . . . . caused by freezing temperatures.

COLD INJURY PREVENTION

___ Wear or carry adequate clothing.

___ Wear clothing and footgear in loose layers.

___ Protect hands and ears. **DO NOT** touch metal, snow, or other objects with bare hands.

___ Avoid immobilization when the tactical situation permits.

___ Keep dry.

___ Use the buddy system and observe for signs and symptoms.

PREVENTIVE MEDICINE MEASURES

___ Provide warming tents, hot beverages, and soups for the troops when the situation dictates. **AVOID CAFFEINE**.

___ Use the windchill chart and plan accordingly.

FROSTBITE CHECKLIST

a. Signs/symptoms:
- ___ Redness, grey, or waxy skin.
- ___ Numb or itchy skin.
- ___ Areas of skin unnaturally firm.
- ___ Tender or swollen skin.

b. Action:
- ___ Shelter victim; keep warm with clothing or body heat, unless individual must walk.
- ___ Remove clothing from affected part; wrap loosely in dry sterile dressing, unless individual must walk.
- ___ **DO NOT** massage area or break blisters.
- ___ **Evacuate the individual to the MTF** (treat as litter casualty, if possible).

HYPOTHERMIA/COLD WEATHER INJURY CHECKLIST

a. Signs/symptoms:
- ___ Lowered body temperature.
- ___ Violent uncontrolled shivering.
- ___ Lack of coordination.
- ___ Memory loss.
- ___ Irrationality.
- ___ Lethargy.
- ___ Slurred speech.

b. Action:
- ___ Move victim to sheltered area, cover, and warm.
- ___ Have conscious patient to drink warm liquids.
- ___ Replace wet clothing with dry, if possible.
- ___ Use sleeping bag to insulate patient from ground.
- ___ Keep patient awake and drinking fluids.
- ___ **DO NOT** rub skin or give individual alcohol.
- ___ **Evacuate the individual to the MTF. THIS IS A MEDICAL EMERGENCY.**

ANNEX Z

HEAT INJURIES

CATEGORIES OF HEAT INJURIES

___ Mild heat reaction.

___ Heat cramps.

___ Heat exhaustion.

___ Heat stroke.

MILD HEAT REACTION

a. Cause: lack of fluids.

b. Signs/symptoms:
   ___ Lightheadedness.
   ___ Fatigue.
   ___ Normal temperature.

c. Action:
   ___ Rest.
   ___ Oral fluids.

HEAT CRAMPS

a. Cause: Lack of electrolytes (sodium, potassium, etc.).

b. Signs/symptoms:
   ___ Cramps in muscles, usually arms, legs, and/or abdomen.
   ___ Normal temperature.

c. Action:
   ___ Rest.
   ___ Oral electrolytes (if patient able to take) or intravenous fluids with electrolytes.
   ___ **RECOMMEND:**
      ___ Rapid evaluation by medical officer.
      ___ No strenuous activity in heat for 12 - 24 hours.

HEAT EXHAUSTION

a. Cause: Loss of fluids.

b. Signs/symptoms:
   ___ Severe fatigue.
   ___ Anxiety.
   ___ Possible loss of consciousness (fainting).
   ___ Cool, pale, clammy skin.
   ___ Temperature below or slightly above normal.

c. Action:
   ___ Remove patient from heat.
   ___ Elevate legs.
   ___ If conscious, give frequent small amounts of oral fluids. If unconscious, give intravenous fluids.
   ___ **RECOMMEND:**
      ___ Immediate evaluation by medical officer.
      ___ Remove patient from heat stress for at least 48 hours.

HEAT STROKE

a. Cause: Failure of body's heat loss mechanisms.

b. Signs/symptoms:
   ___ Hot dry, flushed skin.
   ___ Decreased sweating.
   ___ Rapid pulse.
   ___ Normal or elevated blood pressure.
   ___ Disorientation or unconsciousness.
   ___ Elevated temperature (greater than 101°F, central body temperature, NOT ORAL TEMPERATURE).

c. Action: **This is a medical emergency!**
   ___ Cool patient rapidly.
   ___ Immediately, evacuation patient to the hospital.
   ___ Profile after hospital discharge will provide instructions.

SOLDIER PERFORMANCE IN MOPP GEAR

___ MOPP gear considered a special case of heat stress.

___ Impermeable garment creates uncompensable heat stress.

___ Other problems created by MOPP include:
   ___ Reduced peripheral vision.
   ___ Loss of fine dexterity due to gloves, etc.
   ___ Claustrophobia (in some people).

ANNEX AA

WET BULB GLOBE TEMPERATURE INDEX

BASIC MEASURES

___ Take steps to prevent heat injury to personnel.

___ Train for heat injury prevention.

___ Determine the WBGT index.

___ Ensure personnel actually drink an adequate amount of water.

___ Ensure adequate amount potable water is available.

PREVENTION OF HEAT INJURY CHECKLIST

Be sure soldiers:

___ Replace water loss frequently.
___ Avoid excessive salt intake.
___ Maintain acclimatization.
___ Maintain good physical condition.
___ Protect from environment by wearing proper clothing.

WBGT Index		Physical Activity Recommendations
78°F (26°C)	___	Use caution.
	___	Extremely intense physical exertion may bring on heat exhaustion or heatstroke.
82°F (28°C)	___	Use discretion in planning heavy exercise for unseasoned personnel.
85°F (29°C)	___	Suspend strenuous exercise such as marching at standard cadence for unseasoned personnel during their first three weeks of training.
	___	Training activities may be continued on a reduced scale after the second week of training.
Above 85°F (29°C)	___	Avoid outside classes in the sun when the WBGT is over this WBGT Index.
88°F (31°C)	___	Stop strenuous exercise for all recruits and other trainees with less than 12 weeks training in hot weather.
	___	Hardened personnel, after having been acclimatized each season, can carry on limited activity at WBGT Index of 88°F to 90°F (31°C - 32°C for periods not exceeding six hours a day.
90°F (32°C) and above	___	Suspend physical training and strenuous exercise for all personnel (excluding essential operational commitments not for training purposes, where the risk of heat casualties may be warranted).

NOTE: Wearing of body armor or NBC warfare protective overgarments adds 10°F (6°C) to the measured WBGT. Adjust activity limits accordingly.

ANNEX BB

STABILITY AND SUPPORT OPERATIONS CHECKLIST

COMBAT HEALTH SUPPORT PLANNING CHECKLISTS

COMBAT HEALTH SUPPORT ASSESSMENT CHECKLIST
This checklist is a tool for use in assessing the health care delivery system and the medical needs of a host nation.

Country_____ Dates visited_____

I. General Information
- ___ Name of location
- ___ Map grid coordinates
- ___ Topography (such as mountains or desert)
- ___ Climate (such as tropic or arctic)
- ___ Temperature Ranges
- ___ Summer _____to_____
- ___ Winter _____to_____
- ___ Significant seasonal variants (such as a monsoon season)
- ___ Availability of water (source, quality, quantity, contaminants)
- ___ Epidemiology (disease and occurrence)
- ___ Leading causes of death
- ___ Status of sanitation impacting on the overall health
- ___ Insects, plants, and animals of medical importance
- ___ Religious, social, and/or political factors of medical importance

II. Civilian Health Services
- ___ Organizations and administration (to include public and private)
- ___ Public health laws
- ___ Accessibility to care (to include physical, social, and financial barriers)
- ___ Comments on overall quality of civilian health care
- ___ Significant Individuals (name and title)

III. Military Medical Services
- ___ Force strength (active and reserve)
- ___ Organization and administration
- ___ Policies and programs
- ___ Physical fitness standards
- ___ Medical logistics and blood management
- ___ Medical evacuation and regulating
- ___ Hospitalization
- ___ Preventive medicine
- ___ Dental
- ___ Veterinary
- ___ Pharmacy, laboratory, and x-ray
- ___ Combat stress/neuropsychiatry
- ___ Nursing
- ___ Paraprofessionals
- ___ Military medical training and education programs (course/school, location, and type of training)
- ___ Comments on the overall quality of military medical care
- ___ Significant Individuals (name and title)

IV. Medical Materiel
- ___ Production capability (product, quality, and demand)
- ___ Stockpiles (product, quantity, and demand)
- ___ Products obtained from outside sources (product, quantity, and demand)
- ___ Equipment repair capability

V. Medical Research and Development
- ___ Institutes (Name, location, and type of research)
- ___ Significant individuals

VI. Civilian Medical Training
- ___ Schools/institutes (Name, location, and type of training)
- ___ Significant individuals

VII. Hospitalization Data
- ___ Type
- ___ Military
- ___ Civilian
- ___ Peacetime capacity
- ___ Wartime capacity
- ___ Access
- ___ Road
- ___ Air (both fixed- and rotary-wing)
- ___ Rail
- ___ Water
- ___ Services
- ___ Emergency room
- ___ Operating room
- ___ Intensive care units
- ___ Orthopedics
- ___ Neurosurgery
- ___ Obstetrics
- ___ X-ray
- ___ Laboratory
- ___ Blood bank
- ___ Pharmacy
- ___ Physical therapy
- ___ Occupational therapy
- ___ Dialysis
- ___ Psychiatry
- ___ Comments

MEDICAL MISSION RECONNAISSANCE CHECKLIST

The individual medical mission under a humanitarian assistance program requires comprehensive planning and prior coordination to ensure success. This checklist is a tool for the CHS planner to use prior to deploying a medical team to the AO. (**NOTE**: The terms used for organizations or individuals may vary between health care delivery systems.)

Name of village_____
Grid_____
Sheet number_____

A. Resources available in village and surrounding vicinity
   (1) Communications means, accessibility, and emergency services.
      ___ Communications means (telephone, telegraph, radio, or other)
      ___ Type of road network (paved, dirt, or path)
      ___ Fire/search and rescue services (location)
      ___ Police
      ___ Militia
   (2) Health workers
      ___ Health guardian
      ___ Midwife
      ___ Health representative
   (3) Other personnel available
      ___ School teacher
      ___ Village leader
      ___ Others
   (4) Nearest medical clinic
      ___ Distance
      ___ Transportation available
      ___ Number and type of staff (to include specialties)
      ___ Name of the head nurse
      ___ Name of the health promoter
      ___ Others
   (5) Nearest district or regional medical center
      ___ Distance
      ___ Transportation available
      ___ Number and type of staff (names of physicians/social services)
   (6) Nearest hospital (public and private) and type of hospital
      ___ Area hospital and distance
      ___ Regional hospital and distance
      ___ National hospital and distance
   (7) Private physicians (names, addresses, and specialties)
   (8) Essential drug listing (medications used on humanitarian assistance missions should be consistent with local products and availability)
   (9) Medical logistics availability (materiel, services, and repair capability)
B. Health Information
   (1) Size of population
      ___ Adults
      ___ Children
      ___ Infants

(2) Housing and accessibility of hygiene and sanitation measures
- ___ Number of houses and typical type of construction to include heating
- ___ Latrines
- ___ Water pump
- ___ Water source and how used (bath, laundry, and cooking)

(3) Endemic diseases
(4) Five leading causes of death
(5) Veterinary information
- ___ Number of cattle; horses/mules; goats; pigs; poultry; and dogs and cats
- ___ Number of animals which died in the last 3 months
- ___ Cause or reason for death
- ___ Zoonotic diseases

(6) Dental care information
- ___ General level of oral health
- ___ Endemic oral diseases
- ___ Availability of dental care
- ___ Names of dental care providers

(7) General living conditions
- ___ Clothes (type and quantity [such as in winter are there sufficient coats/warm clothing)
- ___ Housing
- ___ Electricity
- ___ Number of family radios/televisions
- ___ Stores (type and quantity)
- ___ Crops
- ___ Main food sources
- ___ Main sources of income
- ___ Average family income
- ___ Availability of refrigeration
- ___ Type of health care to be given
- ___ Estimation on reliability of information

C. Transportation Information
- ___ Air (type of aircraft and available/adequacy of landing zone)
- ___ Ground (type of vehicle, special requirements (such as snow chains)
- ___ Estimated travel time
- ___ Other

D. Security Information
- ___ Threat
- ___ Host nation and US security forces in the area
- ___ Agency responsible for security and crowd control

E. Diagram of Mission Area
- ___ Draw diagram of mission area to include landmarks and obstacles
- ___ Explain on-site triage layout
- ___ Explain patient flow
- ___ Other

F. Items Required to Support Mission
- ___ Medical supplies
- ___ Medical equipment
- ___ Nonmedical supplies and equipment

G. Photographs of Significant Features and People
H. Assessment Made by: (names and titles)
I. Expected Dates of Mission

ANNEX CC

SINCGARS OPERATIONS

SINGLE CHANNEL OPERATIONS (SC)

___ Load/store SC frequencies
- ___ Move to desired channel.
- ___ Set FCTN to LD.
- ___ Set mode to SC.
- ___ Press FREQ button.
- ___ Press CLR button.
- ___ Enter desired frequency.
- ___ Press STO/ENT.

___ Clear SC frequencies
- ___ Move to desired channel.
- ___ Set FCTN to LD.
- ___ Set mode to SC.
- ___ Press freq button.
- ___ Press CLR button.
- ___ Press H.LD/0 button.
- ___ Press STO/ENT.

___ Offset SC frequencies
- ___ Select desired channel
- ___ Set mode to SC.
- ___ Set FCTN to SQ/0N.
- ___ Press send/OFST button.
- ___ Press CLR button.
- ___ Press 5 or 10.
- ___ Press SEND/OFST again for A(-)5 or 10.
- ___ Press STO/ENT button.

___ Clear offset frequencies
- ___ Select desired channel.
- ___ Set mode to SC.
- ___ Set FCTN to SQJON.
- ___ Press SEND/OFST button.
- ___ Press CLR button.
- ___ Press H.LD/O button.
- ___ Press STO/ENT button.

___ Scan SC frequencies
- ___ Set FCTN to SQ/0N.
- ___ Set mode to FH.
- ___ Set CHAN to CUE.
- ___ Press STO/ENT button.
- ___ Press 0-7 for desired priority or press 8 if no desired priority.

___ Cancel a channel from scan
- ___ Press channel number to be cleared
- ___ Press CLR button

NOTE: You cannot clear a priority channel from scanning.

___ Restore a channel to scan
- ___ Press channel number to be restored.

FREQUENCY HOP-SUBSTATION OPERATIONS (FH)

___ Prepare to receive (ERF) cold start NET opening
- ___ Set CHAN to MAN.
- ___ Set FCTN to LD.
- ___ Set MODE to SC.
- ___ Press FREQ button.
- ___ Press CLR button.
- ___ Enter desired frequency.
- ___ Press STO/ENT.
- ___ Set FCTN to LDIV.
- ___ Set mode to FH.
- ___ Turn ECCM fill device off.
- ___ Connect ECCM device to the fill audio connector on radio.
- ___ Select TI or T2 from ECCM fill device.
- ___ Turn ECCM fill device on.
- ___ Press H.LD/O button.
- ___ Turn ECCM fill device off.
- ___ Disconnect ECCM fill device QSET FCTN to LD.
- ___ STNDBY and follow instructions from NCS.

___ Prepare to receive (ERF) update
- ___ Set FCTN to LD.
- ___ Standby and follow instructions from NCS.

NOTE: SET FCTN TO SQ/ON AFTER COMPLETING (ERF) UPDATE OPERATION

___ Perform late NET entry
- ___ You have not received any traffic for 20 minutes.
- ___ Set FCTN to SQ/ON.
- ___ Set MODE to FH.
- ___ Press FREQ button.
- ___ Press L.E/3 button.
- ___ Wait at least 2 minutes.

NOTE: DO NOT KEY HANDSET UNTIL "L" DROPS FROM DISPLAY.

___ Clear a late NET entry
- ___ Press FREQ button.
- ___ Press L.E/3.

___ Perform "CUE" function
- ___ You performed a late NET entry but still have no COMMO.
- ___ Turn KY-57 off.
- ___ Set CHAN to CUE.
- ___ Set MODE to LD.
- ___ Press FREQ button.
- ___ Press CLR button.
- ___ Enter desired frequency.
- ___ Press STO/ENT button.
- ___ Set FCTN to SQ/ON.
- ___ Key HANDSET for 4 seconds. Unkey for 15 seconds. Continue until contact is made.
- ___ Follow instructions of NCS.

NOTE: Clear cue frequency when you have completed this operation.

___ Change HOP set I.D. number
- ___ Select desired channel containing the HOPSET to be changed.
- ___ Press FREQ button.
- ___ Press CLR button.
- ___ Enter new HOPSET I.D. number.
- ___ Press STO/ENT button.

___ Perform cold start NET operations as an NCS
- ___ Set CHAN to MAN.
- ___ Press H.LD/O button.
- ___ Press U9 button.
- ___ Press 1 ST DIGIT of lockout.
- ___ Contact the NET and ask them to stand by for ERF.
- ___ Press SEND/OFST button twice.
- ___ Tell NET to press STO/ENT button.
- ___ Press STO/ENT button.
- ___ Press H.LD/0 button.
- ___ Press channel number that hopset is stored in
- ___ Press SEND/0FST button twice.
- ___ Tell the NET to press STP/ENT button and 1-6 as directed by you.
- ___ Tell NET to go to the channel the hopset is stored in and SQ/ON.
- ___ Make a radio check. Then, go to SQ/ON.

NOTE: If lockout is not required, perform only the first three steps.

___ Send ERF update
- ___ Set FCTN told.
- ___ Press H.LD/o button.
- ___ Press the channel number HOPSET update is stored in.
- ___ Tell NET to stand by for ERF update
- ___ Press SEND/OFST twice.
- ___ Tell NET to press STO/ENT button and ___channel number that you want HOPSET update stored in.
- ___ Press STO/ENT and channel number that HOPSET update is stored in.
- ___ Tell NET to go to channel that HOPSET update is stored in.
- ___ Make a radio check then go to SQ/ON.

___ Clear a lockout
- ___ Set CHAN to MAN.
- ___ Set FCTN to LD
- ___ Press clr button.
- ___ Press l/9 button.
- ___ Press 1st digit of the lockout.

___ Clear a HOPSET
- ___ Set CHAN to MAN.
- ___ Set FCTN told.
- ___ Press CLR button.
- ___ Press channel number that contains the HOPSET data that you want to clear.

FREQUENCY HOP MASTER FUNCTIONS (NCS) CHECKLIST

___ Load MAN and CUE frequencies
- ___ Set FCTN to LO.
- ___ Set MODE to SC.
- ___ Set CHAN to MAN.
- ___ Press FREQ button.
- ___ Press CLR button.
- ___ Enter desired frequency.
- ___ Press STO/ENT button.
- ___ Set CHAN to CUE
- ___ Press FREQ button.
- ___ Press CLR button.
- ___ Enter desired frequency.
- ___ Press STO/ENT button.

___ Load TRANSEC
- ___ Set mode to FH.
- ___ Set fctn to LD/V.
- ___ Set CHAN to MAN.
- ___ Turn ECCM FILL device off.
- ___ Connect ECCM FILL device to fill audio connector on radio.
- ___ Turn ECCM fill device on
- ___ Select T1 or T2 from ECCM fill device.
- ___ Press H.Ld/o button.
- ___ Set FCTN to LD.

___ Load lockout
- ___ Select desired lockout from ECCM fill device.
- ___ Press H.LD/o button.
- ___ Press STO/ENT button.

NOTE: If lockout not used, skip this.

___ Load HOPSET
- ___ Select desired HOPSET from ECCM fill device.
- ___ Press H.LD/o button.
- ___ Press STO/ENT button.
- ___ Press KEY PAD for desired channel 1-6.
- ___ Turn ECCM FILL device off.
- ___ Disconnect ECCM FILL device.

___ Load TIME
- ___ Press TIME button.
- ___ Press CLR button.
- ___ Enter current JULIAN DATE.
- ___ Press STO/ENT button.
- ___ Press TIME button.
- ___ Press CLR button.
- ___ Enter CURRENT ZULU TIME.
- ___ Press STO/ENT button.

NOTE: Load time only if you did not receive an ERF from higher.

ANNEX DD

OPERATIONS IN A NUCLEAR, BIOLOGICAL, AND CHEMICAL ENVIRONMENT

INTRODUCTION

Nuclear, biological, and chemical actions create:

___ High casualty rates.
___ Materiel losses.
___ Obstacles to maneuver.
___ Contamination.

GENERAL

Contamination is the major problem in providing CHS in an NBC environment. To increase survivability as well as supportability units must take actions to avoid NBC contamination. Maximum use will be made of:

___ Alarms and detection equipment.
___ Unit dispersion.
___ Overhead cover, shielding materials, and collective protection shelters (CPS), when available.

COMPANY RESPONSIBILITIES

The commander will ensure that all personnel have their immunizations up to date; have begun taking biological warfare agent prophylaxis as prescribed; are using skin protectants; and have complete chemical protection overgarments.

___ The company NBC NCO is responsible for ensuring that the company has completed NBC protective procedures in accordance with the unit TSOP. He will ensure that all necessary reports (such as NBC 1) are posted in the company CP, as required. He will notify the commander immediately when the unit is determined to be in noncompliance with the unit NBC SOP.

PLATOON RESPONSIBILITIES (NOTE: Medical platoon in maneuver units; all platoons in medical company)

___ Each platoon is responsible for ensuring that they have at least two individuals trained in basic NBC protection. These individuals will assist the NBC NCO in the performance of his duties as the situation permits.

PLATOON LEADERS' RESPONSIBILITIES

Platoon leaders are responsible for ensuring their platoons have:

___ Checked all NBC gear to include M8A1 alarms.
___ Individual protective masks.
___ Individual protective overgarments.
___ Taken general NBC hardened of their areas daily.
___ Individual decontaminating kits, nerve agent antidotes (MARK I and CANA), pretreatments, if available, and up-to-date immunizations.

M8A1 ALARM AND WD1 WIRE

___ Placement.
- ___ M8A1 alarms will be placed 150 meters upwind from the perimeter.
- ___ WD1 wire will be concealed or buried. The wire will be attached to a stationary object before it is attached to the alarm.

___ The alarm and wire will be checked daily.

NBC ATTACK

Upon notification of an imminent NBC attack:
- ___ All soldiers will immediately seek shelter and assume the directed MOPP level.
- ___ Movement in exposed areas should be kept to a minimum.
- ___ Leaders will then inspect the NBC protective posture in their area as time permits.

NBC-1 REPORTS

___ Immediately following the attack, units will prepare and submit NBC-1 reports to the company CP. NBC-1 reports will be consolidated and submitted to the battalion TOC.

ACTION AND UPDATES

___ The battalion TOC will direct what action will be taken. Units will continue to update the company CP on any developments such as casualties, contamination of equipment, and updated NBC-1 reports.

MEDICAL/TREATMENT PLATOON RESPONSIBILITIES

___ The platoon must be prepared to conduct patient decontamination operations as required. They require at least eight nonmedical personnel to perform the patient decontamination procedures.

LIFESAVING MEASURES

___ Lifesaving measures will be performed on patients, regardless of contamination.

CLEAN AND CONTAMINATED AMBULANCES/VEHICLES/PERSONNEL

___ Care must be taken to ensure that contaminated patients **DO NOT** enter clean facilities.

___ Air and ground units contaminated in the original attack remain in the contaminated area until the mission is complete or directed to withdraw and be decontaminated.

___ Noncontaminated ambulances/vehicles/personnel should not enter contaminated areas unless directed by the leader. If additional medical evacuation assets are required to be employed in the contaminated area, it is preferable to commit ground evacuation resources rather than air ambulances.

UNMASKING PROCEDURES

___ Unmasking procedures will be:
- ___ Directed by the leader.
- ___ Monitored by the company NBC NCO and leader.

WATER SOURCE INSPECTIONS

___ The NBC NCO and the attached PVNTMED team will conduct routine inspections of the water sources of the battalion to ensure no contamination has taken place. In the event of an NBC attack these sources must be checked more frequently.

NBC CHECKLIST

Ensure:

___ All soldiers can operate NBC defense equipment.
___ NBC defense equipment is operational/functional.
___ All soldiers know how to prepare and send NBC 1 and NBC 4 reports.
___ All soldiers recognize and know how to react to chemical and biological hazards.
___ All soldiers know criteria for automatic masking.
___ All soldiers enforce MOPP levels.
___ All soldiers can administer self and buddy aid for nerve agent poisoning.
___ All personnel can perform hasty DECON and MOPP gear exchange.

MOPP LEVEL	BDO	BOOTS	MASK	GLOVES
0	CARRIED	CARRIED	CARRIED	CARRIED
1	WORN	CARRIED	CARRIED	CARRIED
2	WORN	WORN	WORN	CARRIED
3	WORN	WORN	WORN	CARRIED
4	WORN	WORN	WORN	CARRIED

UNMASKING PROCEDURES WITHOUT M256A1

___ Move to shady area.
___ Have two or three soldiers take a deep breath and break the seal on their masks 15 seconds with their eyes open.
___ Have soldier clear and reseal their masks.
___ Observe for signs/symptoms for 10 minutes.
___ Have the same soldiers break their seals, take two or three breaths, and clear and reseal their masks.
___ Observe for signs/symptoms for 10 minutes.
___ Have the same soldiers unmask for 5 minutes, then remask.
___ If no symptoms appear in 10 minutes, the commander can direct unmasking.
___ Continue to observe soldier.

UNMASKING PROCEDURES WITH M256 OR M256A1 DETECTOR KIT

___ Execute M256 or M256A1 detector kit.
___ If negative, have two soldiers unmask for 5 minutes, then remask.
___ If no symptoms are present in 10 minutes, the commander can direct unmasking.
___ Continue to observe soldiers for signs/symptoms.

ANNEX EE

PATIENT DECONTAMINATION OPERATIONS

PREPARE PATIENT DECONTAMINATION CHLORINE SOLUTIONS

___ Two concentrations of the chlorine solution are required.
- ___ A 5% solution is required to decontaminate:
  - ___ Gloves.
  - ___ Aprons.
  - ___ Litters.
  - ___ Scissors.
  - ___ The patient's hood.
  - ___ Other non-skin contact surfaces.
- ___ Another 0.5% solution is required to decontaminate:
  - ___ The patient's mask, skin and splints.
  - ___ Irrigate patient's wounds.

___ Solution preparation.
- ___ Use calcium hypochlorite (HTH) granules (supplied in 6 ounce jars in the patient decontamination MES) or sodium hypochlorite (household bleach).
- ___ Prepare the required concentrations as shown in the table which follows.

HTH ounces	HTH MRE spoonfuls	Hoursehold bleach	Percent in 5 gallons of water
6	5*	2 quarts	0.5
46	35	**	5

* Use the plastic spoon supplied in your MRE to measure. The amount of HTH to be used is a heaping spoonful.

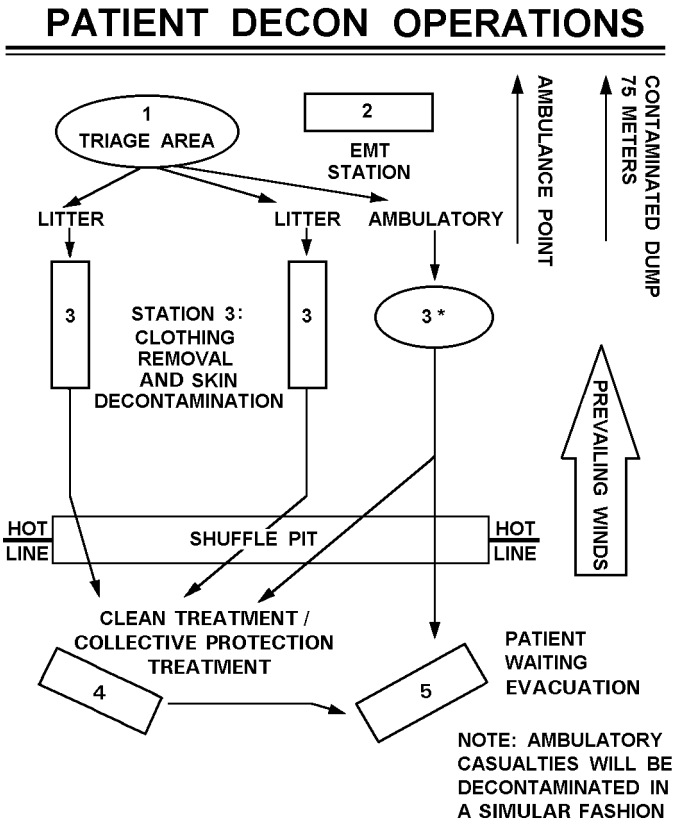
** DO NOT dilute in water. Household bleach is a 5% solution.

DECONTAMINATE A CHEMICAL AGENT LITTER PATIENT

___ STEP 1. Decontaminate the patient's mask and hood.
___ STEP 2. Remove gross contamination.
___ STEP 3. Remove the patient's CPOGS and personal effects.
___ STEP 4. Remove the patient's battle dress uniform.
___ STEP 5. Transfer the patient to a decontamination litter.
___ STEP 6. Skin decontamination.
___ STEP 7. Transfer the patient across the shuffle pit.

DECONTAMINATE A CHEMICAL AGENT AMBULATORY CASUALTY

___ STEP 1. Remove LBE.
___ STEP 2. Decontaminate the patient's mask and hood.
___ STEP 3. Remove the FMC.
___ STEP 4. Remove all gross contamination.
___ STEP 5. Remove overgarment.
___ STEP 6. Check patient for contamination.
___ STEP 7. Decontaminate the patient's skin.
___ STEP 8. Remove bandages and tourniquets.
___ STEP 9. Proceed through the shuffle pit to the treatment area.



ANNEX FF

SPOT REPORT/SALUTE

In accordance with FM 8-10-8, *Medical Intelligence in a Theater of Operations*, medical personnel who gain information through casual observation of activities in plain view in the course of the discharge of their humanitarian duties will report it to their supporting intelligence element (S2 or G2) quickly, completely, and accurately using the Spot Report (SALUTE format).

SPOT REPORT/SALUTE	
LINE	**ITEM**
1	SIZE
2	ACTIVITY
3	LOCATION
4	UNIT/UNIFORM
5	TIME OBSERVED
6	EQUIPMENT
NOTES:	

ANNEX GG

HANDLING ENEMY PRISONERS OF WAR

Medical units may have enemy soldiers surrender. They must hold these EPW until they can be transferred/moved to the EPW collection point. They should be handled as discussed in the table below. (**NOTE**: Medical units do not guard EPW patients. If required, guards are provided by the echelon commander.)

HANDLING ENEMY PRISONERS OF WAR

ITEM	ACTION
1	**SEARCH** - remove, tag & mark weapons, documents; return personal items, helmet, NBC GEAR
2	**SEGREGATE** - by rank, sex, military, civilian
3	**SILENCE** - no talking
4	**SPEED** - from battle area
5	**SAFEGUARD** - to prevent harm or escape

NOTES:

ANNEX HH

PROFESSIONAL OFFICER FILLER SYSTEM (PROFIS) PERSONNEL CHECKLIST

Pre-deployment Checklist

___ Obtain issue of TA-50
___ Ensure immunizations are up-to-date
___ Ensure family care plans and other legal documents are up-to-date
___ Contact the unit of assignment to ascertain any special requirements
___ Make travel arrangements

Upon Arrival at Unit

___ Report to the commander to ascertain--
  ___ Duty assignment
  ___ Mission priorities
  ___ General threat (to include antiterrorism and force protection guidance)
  ___ Medical threat (to include endemic and epidemic diseases)
  ___ Unit layout
___ Coordinate with unit first sergeant for--
  ___ Billeting
  ___ Field feeding (location, hours of operation)
  ___ Laundry and bath services
  ___ Field sanitation procedures
  ___ Duty rosters
  ___ Training schedule
___ Report to duty section
  ___ Meet section members
  ___ Review section SOP
  ___ Determine hours of operations/shifts
  ___ Meet and coordinate with individuals/organizations within your technical chain (such as brigade surgeon)
  ___ Familiarize yourself with field medical equipment and medical equipment sets (MESs)
  ___ Determine resupply procedures
  ___ Determine medical waste and general waste disposal procedures

ACRONYMS

1LT first lieutenant
A²C² Army airspace command and control
AA Active Army/air ambulance
AAFES Army and Air Force Exchange Service
AAR after action review
AASLT air assault
AC Active Component
AD armored division
ADA air defense artillery
ADT active duty for training
AE aeromedical evacuation
AECC Aeromedical Evacuation Control Center
AECE Aeromedical Evacuation Control Element
AELT aeromedical evacuation liaison team
AG Adjutant General
AHS Academy of Health Sciences, U.S. Army
AIT advanced individual training
ALOC Administrative and Logistics Operations Center
AMC Air Mobility Command (United States Air Force)/Army Materiel Command
AMEDD Army Medical Department
AMEDDC&S U.S. Army Medical Department Center and School
AML area medical laboratory/Advanced Medical Laboratory (Course)
AMSC Army Management Staff College/Army Medical Specialist Corps
AN Army Nurse Corps
ANCOC Advanced Noncommissioned Officer Course
AO area of operations
AOC area of concentration
AOR area of responsibility
APFT Army Physical Fitness Test
AR Army Regulation
ARC American Red Cross
ARCOM Army Reserve Command/Army Commendation Medal
ARNG Army National Guard
ARPERCEN Army Reserve Personnel Center
ARTEP Army Training and Evaluation Program
as as stated
ASAP as soon as possible
ASB aviation support battalion
ASF aeromedical staging facility
ASI additional skill identifier
ASL authorized stockage list
ASMB area support medical battalion
ASMC area support medical company
ASMS area support MEDEVAC section
ASP ammunition supply point
AT annual training
ATC air transportable clinic (United States Air Force)
ATM advanced trauma management
ATP ammunition transfer point
AXP ambulance exchange point
BAQ basic allowance for quarters
BAS battalion aid station/basic allowance for subsistence

BASD basic active service date
BCT battalion combat team/brigade combat team
BCTP battle command training post
BDAR battle damage assessment and repair
BDE brigade
BDU battle dress uniform
BEQ bachelor enlisted quarters
BFC battle fatigue casualty
BII basic issue item
BMNT beginning of morning nautical twilight
BN battalion
BNCOC Basic Noncommissioned Officer Course
BOA basis of allocation
BOS battlefield operating systems
BP battle position
BSA brigade support area
BSEP Basic Skills Education Program
C^2 command and control
C^3 command, control, and communications
C^4 Combat Casualty Care Course
C^4I command, control, communications, computers, and intelligence
CAA Combined Arms Army
CAB combat aviation brigade
CANA convulsant antidote for nerve agent
CAP company aid post
CAS close air support
CAS3 Combined Arms Service Staff School
CAV cavalry
CCP casualty collecting point
CCCP chemical casualty collecting point
CCIR commander's critical intelligence requirements
CCL combat configured load
CCP combat collection point
CDR commander
CFA covering force area
CFFS combat field feeding system
CG commanding general
CHAMPUS Civilian Health and Medical Program of the Uniformed Services
CHL combat health logistics
CHS combat health support
CL combat lifesaver
CLOAC Combat Logistics Officer Advanced Course
CLS clearing station
CMF career management field
CMS central materiel supply
CMTC Combat Maneuver Training Center
CO company/commanding officer
COB close of business/command operating budget
COL colonel/chief of logistics
COMMZ communications zone
CONUS continental United States
COR contract officer representative
COSCOM corps support command
CP command post

CPOG chemical protective overgarment
CPR cardiopulmonary resuscitation
CPS collective protective shelter
CPT captain
CPX command post exercise
CRAF Civil Reserve Air Fleet
CRTS casualty receiving and treatment ship
CS combat support
CSS combat service support
CSAR combat search and rescue
CSB corps support battalion
CSC combat stress control
CSG combat support group
CSH combat support hospital
CSR controlled supply rate
CSS combat service support
CTA common table of allowances
CTC combat training center
CZ combat zone
DA Department of the Army
DAC Department of the Army Civilian
DAO division ammunition officer
DBA deep battle area
DC Dental Corps
DCSPER Deputy Chief of Staff for Personnel
D-Day day of operation
DECON decontamination
DENTAC US Army Dental Activity
DEPMEDS Deployable Medical Systems
DES dental equipment set
DF2 diesel fuel type 2
DHHS Department of Health and Human Services
DISCOM division support command
DIVARTY division artillery
DMMC division material management center
DMOC division medical operations center
DMSET Deployable Medical Systems equipment for training
DNBI disease and nonbattle injuries
DOA dead on arrival
DOD Department of Defense
DOL Directorate of Logistics
DOS days of supply
DOW died of wounds
DRT Doctrine Review Team
DS direct support
DSA division support area
DST decision support template--shows decision points keyed to significant events and activities
DSU direct support unit
D-TACC Deployed Tanker Airlift Control Center
DTF dental treatment facility
DTG date-time group
DTOC division tactical operations center
DVA Department of Veterans Affairs
DZ drop zone

EAC echelon above corps
ECCM electronic counter-countermeasures
EEFI essential elements of friendly information
EENT end of evening nautical twilight
EFMB Expert Field Medical Badge
ELO enabling learning objective
EMT emergency medical treatment/emergency medical technician
EOD explosive ordinance disposal
EPMS Enlisted Personnel Management System
EPW enemy prisoners of war
ESF emergency support function
ETA estimated time of arrival
ETS expiration of term of service
EVAC evacuation
FAO Finance and Accounting Office
FARP forward arming and refueling point
FEBA forward edge of the battle area
FEMA Federal Emergency Management Agency
FH field hospital
FLOT forward line of own troops
FM field manual
FMC US Field Medical Card (DD Form 1380)
FONECON telephone conversation
FORSCOM US Forces Command
FRAGO fragmentary order
FSB forward support battalion
FSMC forward support medical company
FSMT forward support MEDEVAC team
FSP forward supply point
FST forward surgical team
FTX field training exercise
FY fiscal year
GA ground ambulance
GH general hospital
GR general reference
GRREG graves registration
GS general support
GTA graphic training aid
HEMTT heavy expanded mobility tactical truck
HET heavy equipment transporter
HMMWV high mobility multi- purpose wheeled vehicle
HQ headquarters
HSC headquarters and support company
HSSO health service support officer
HUB hospital unit, base
HUH hospital unit, holding
HUM hospital unit, medical
HUS hospital unit, surgical
IAW in accordance with
ID identification
IEDK individual equipment decontamination kit
IET Initial Entry Training
IG Inspector General
INFO information

INTEL intelligence
IPB intelligence preparation of the battlefield
IPR in-process review
IRR Individual Ready Reserve
ISB intermediate staging base
ISO Information Security Officer
ITEP Individual Training Evaluation Program
IV intravenous
JAGC Judge Advocate General's Corps
JCAHO Joint Commission on Accreditation of Healthcare Organizations
JMRTC Joint Medical Readiness Training Center
JP4 jet petroleum, type 4
JRTC Joint Readiness Training Center
kg kilogram
KIA killed in action
km kilometers
LCDR Lieutenant Commander (US Navy)
LD line of departure
LOI letter of instruction
LRP logistics release point
LT Lieutenant
LTC lieutenant colonel
LTG lieutenant general
LZ landing zone
MACOM major Army command
MAJ major
MARC multifunctional automated record card
MASF mobile aeromedical staging facility
MAST military anti-shock trousers
MBA main battle area
MC Medical Corps
MCO movement control officer
MEDCASE Medical Care Support Equipment
MEDCEN US Army Medical Center
MEDDAC US Army Medical Department Activity
MEDEVAC medical evacuation
MEDLOG medical logistics
MEDPAR Medical Patient Administration and Records (TAMMIS)
MEDREG medical regulating
MES medical equipment set
METL mission essential task list
METT-T mission, enemy, terrain, troops, and time available
MF2K Medical Force 2000
MFR memorandum for record
MFSS Medical Field Service School
MG Major General
MH mental health
MIA missing in action
MILES Multiple Integrated Laser Equipment System
MILPERCEN US Army Military Personnel Center
min minute
MISALL medical information system/AMEDD Lessons Learned
MOA memorandum of agreement
MOGAS motor gasoline

MOPP mission-oriented protective posture
MOS military occupational specialty
MOU memorandum of understanding
MOUT military operations on urbanized terrain
MP military police
mph miles per hour
MPT medical proficiency training
MQS military qualification standards
MRE meal, ready-to-eat
MRO medical regulating office
MS Medical Service Corps
MSB main support battalion
MSG master sergeant
MSMC main support medical company
MSN mission
MSR main supply route
MST maintenance support team
MTF medical treatment facility
MTP Mission Training Plan
MWD military working dog
NAI named area of interest
NAPP nerve agent pretreatment packet
NBC nuclear, biological, chemical
NCO noncommissioned officer
NCOER Noncommissioned Officer Evaluation Report
NCOES Noncommissioned Officer Education System
NCOIC noncommissioned officer in charge
NDMS National Disaster Medical System
NEO noncombatant evacuation operations
NLT not later than
NOK next of kin
NP neuropsychiatric
NSN National Stock Number
NTC National Training Center
OAC Officer Advance Course
OBC Officer Basic Course
OCONUS outside the continental United States
OCS Officer Candidate School
OER Officer Evaluation Report
O&I operations and intelligence
OIC officer in charge
OJT on-the-job training
OP operations
OPCON operational control
OPLAN operation plan
OPORD operation order
OPSEC operations security
OR operating room
OT occupational therapy
OTSG Office of The Surgeon General
OVM on vehicle materiel (equipment)
PA physician assistant
PAC personnel administration center
PAD patient administration division

PAO public affairs office
PBO property book officer
PCP patient Collecting point
PERSCOM US Army Personnel Command
PERSTAT personnel status report
PLDC Primary Leadership Development Course
PLT platoon
PLX pharmacy, laboratory, x-ray/Platoon Leader Exercise
PM preventive maintenance
PMCS preventive maintenance checks and services
POC point of contact
POI program of instruction
POL petroleum, oils, and lubricants
PROFIS Professional Officer Filler System
PT physical training/physical therapy
PVNTMED preventive medicine
PZ pick-up zone
QA quality assurance
QC quality control
QM Quartermaster Corps
QTB quarterly training briefing
RBA rear battle area
RC Reserve Component
REG regulation
RIF reduction In force
ROE rules of engagement
ROTC Reserve Officer Training Corps
RSOI reception, staging, onward movement, and integration
RSR required supply rate
RTD return to duty
S1 Adjutant (US Army)
S2 Intelligence Officer (US Army)
S3 Operations and Training Officer (US Army)
S4 Supply Officer (US Army)
SASP special ammunition supply point
SB support battalion
SDT Self-Development Test
SF standard form
SFC sergeant first class
SGM sergeant major
SGT sergeant
SM service member/soldier's manual
SME subject-matter expert
SOC support operations center
SOI signal operating instructions
SOP standing operating procedure
SP start point
SPT support
SQI special qualification identifier
SSG staff sergeant
SSI specialty skill identifier
SSN social security number
STB super tropical bleach
STX situational training exercise

TA theater Army
TAADS The Army Authorization Documents System
TAI target area of interest
TAMMIS Theater Army Medical Management Information System
TBD to be determined
TCP traffic control point
TDA table(s) of distribution and allowances
TDY temporary duty
T&EO training and evaluation outline
TEWT training exercise without troops
TF task force
TLP troop leading procedures
TM technical manual
TMC troop medical clinic
TOC tactical operations center
TOE table(s) of organization and equipment
TPMRC Theater Patient Movement Requirements Center
TRADOC U.S. Army Training and Doctrine Command
TSG The Surgeon General
TTP trailer transfer point
ULLS Unit Level Logistical System
USA United States Army
USAF United States Air Force
USAREUR United States Army Europe
USAR United States Army Reserve
USMC United States Marine Corps
USN United States Navy
VC Veterinary Corps
VHA variable housing allowance
VIC vicinity
WBGT wet bulb globe temperature
WIA wounded in action
WO warrant officer
WSRO weapons system replacement operations
XO executive officer